Health Services and Facilities Master Plan

FINAL 1/12/06

MESCALERO Service Unit

New Mexico

CL Associates, Inc.
Santa Fe, NM

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Introduction

In the FY 2000 Appropriation Bill for the Public Health Service, the United States Congress directed Indian Health Service (IHS) to determine the level of services and the types of facilities needed to supply these services through the year 2015. The IHS' Office of Environmental Health and Engineering (OEHE) was assigned responsibility for overseeing the process. In February 2003, Dr. Charles Grim, Assistant Surgeon General of the Department of Health and Human Services, instructed all Area IHS offices to develop a Health Services and Facilities Master Plan (HSFMP) to meet the Congressional directive.

The Albuquerque Area IHS assessed its resources and initiated its planning process by October 2003. The Albuquerque Area HSFMP has been developed over 18 months by integrating statistical analysis and site visits with participation from tribes, Service Unit health boards, IHS administration, and medical staff. It is the product of research, community outreach, statistics, analysis, discussion, and document review. Its purpose is to guide the development of health care services and facilities through the year 2015.

Planning for the Mescalero Service Unit (MSU) HSFMP occurred throughout 2004 and early 2005. All of MSU's data will ultimately be blended with the HSFMPs of the eight other Albuquerque Area Service Units, and result in the Albuquerque Area Health Services and Facilities Master Plan.

Appendix A provides a glossary of acronyms and terms used throughout this report. Other documents, most notably the U.S. Commission on Civil Rights report "Broken Promises: Evaluating the Native American Health Care System," and historical information about legislation concerning health care for Indian were reviewed as background information for this report, and they are summarized in Appendix B. Other documents reviewed include "The IHS Strategic Plan: Improving the Health of American Indian and Alaska Native People Through Collaboration and Innovation", January 2003; and "Transitions 2002: A 5 Year Initiative to Restructure Indian Health", October 2002.

Plan Summary

The Mescalero Service Unit HSFMP:

- Provides an overview of the IHS existing hospital and clinical buildings in the Mescalero Service Unit.
- Identifies the services currently provided within those facilities, based on staff input and statistical research;
- Identifies the need, based on user population and projected population, for expanded services and facilities by the year 2015;
- Estimates the amount of investment required to meet these needs;
- Reports significant findings; and
- Proposes strategies to meet the needs identified.

Executive Summary

Despite limited – and decreasing – funding, MSU has demonstrated the ability to provide basic health care to the 4,447 total Active Users within its boundaries. This has been achieved in spite of lower per capita expenditures for health care, estimated by the IHS to be less than 60% of national levels, and lower availability of health care services (25% annual availability of dental services versus 60% for U.S. population overall). Complicating these factors are the limited number of providers – almost 50% less per capita than the U.S. population overall.

The annual IHS budget has increased only approximately 3% per year for facilities and services –much of which must be used for federally mandated "Cost of Living Adjustments" for staff salaries. The impact of this minimal increase on the IHS' ability to provide quality health care services cannot be understated. It has also resulted in under-funding of facilities, equipment, and other capital investment necessary to provide adequate health care services.

While an admirable approach, the "do more with less" medical practice can mean that true health care needs are never fully addressed, preventive care is neglected, and longer term, more serious chronic conditions result. An example is the 2004 decision to restrict medical coverage to Priority One levels of care. The long-term outcomes of these reductions point to an increased – not decreased—health care burden on providers and facilities by the year 2015.

In 2004 the federal appropriation for MSU based on tribal shares and Resident Active User Population was $3,135,796 for staffing of the medical facilities, equipment, and facility management. Another $1.9 million was provided for CHS, while the tribe received $46,496 for its ISDA/638 mental health programs.

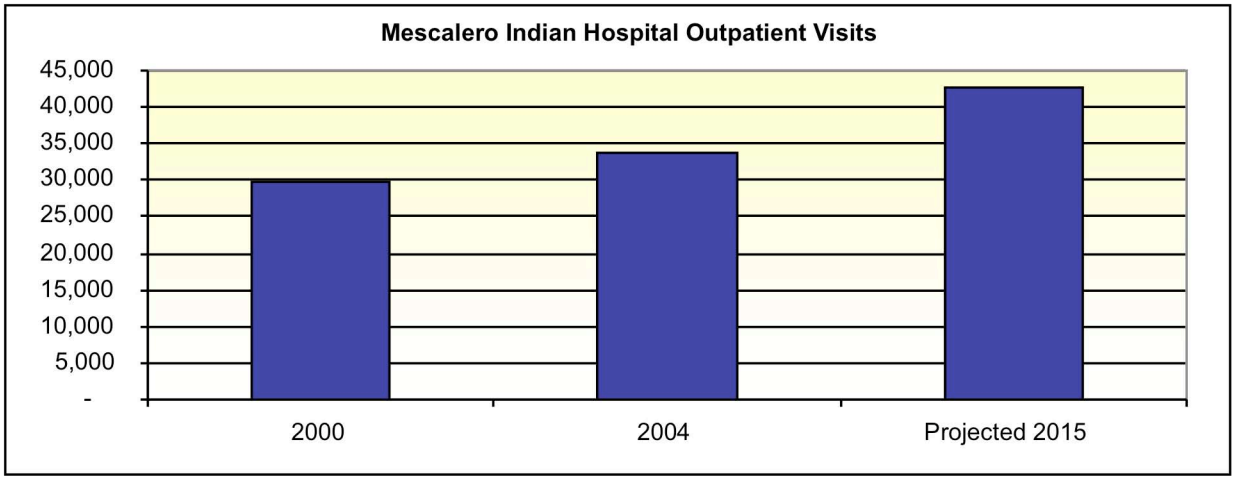
It was supplemented by approximately $1.8 million from third party reimbursements including Medicare and Medicaid. With more than 25% of its revenue dependent on Medicare and Medicaid funding, the MSU will need to make difficult changes to accommodate its future existence.

Current projections by the Social Security and Medicare Boards of Trustees expect the Trust Fund to go broke in the year 2019. Over the next 10 years Medicare and Medicaid funding requirements will become increasingly difficult, and IHS will be progressively more challenged to provide the infrastructure required to meet these new requirements. It is expected that some form of "pay for performance" will be instituted so that payment will be based on performance indicators rather than outcomes.

The existing health facility, built in 1968, was designed as in patient facility with an ambulatory clinic to accommodate regular medical patient visits, laboratory, pharmacy, and dental. The facility has long outgrown its capacity as an outpatient clinic and has been forced to make numerous renovations to accommodate the increased burden in ambulatory care.

This budget 'flat line' comes as the MSU is experiencing substantial growth in outpatient visits. In 2004 the MIH recorded a total of 33,831 outpatient visits, up 13% from 2000 when the MIH recorded 29,830 outpatient visits. Based on historical use patterns the MSU could expect to see at least 42,590 outpatient visits in the year 2015.

MIH Outpatient Visits 2000-2004 with 2015 Projection



As the number of Active User patients grows the number of inpatient admissions is plummeting. Since experiencing a "peak" of inpatient services in 1997 MIH has seen a reduction in admissions/discharges, as well as services provided and the number of providers. The average daily count fell from only 3.2 patients in 1997 to 1.7 in 2004 – extremely low by any hospital industry standard for a viable in-patient facility. Overall occupancy rates fell from 24% or 1,158 patient days/year in 1997, to only 13% or 626 days/year in 2004. By most health planning standards, this is a struggling enterprise at best and it represents a drain on limited resources that could be used to provide better ambulatory care to patients.

In 2004 approximately 23% of patients in the MSU were "Urban" Indians – not enrolled in the Mescalero Apache Tribe and therefore services were provided without reimbursement by IHS. Although some of these patients may be eligible for Medicare and/or Medicaid insurance, many are not.

Based on historical use patterns, the MSU health care delivery system will likely see a 10-15% rise in Active User population by the year 2015. Although the average age of the MSU Active User population is 26 years, 31% of the current population is over 45 years of age and the 45 + age group has grown by 33% over the previous five years. The 65+ age group alone has increased by almost 45% in five years. As the 'bubble' population in the 15-44 range ages, MSU services and facilities will obviously need to change to accommodate more prevention and prepare for diseases known to affect this aging population.

With approximately 23,000 square feet of ambulatory clinic space and 1,800 square feet of inpatient space, the Mescalero Indian Hospital is inadequate to meet current space need for its 4,447 Active Users. Documentation prepared for this Plan indicates that by the year 2015, with 5147 Active Users, the MSU will need an ambulatory facility of at least 45,402 square feet (4218 square meters).

In summary, by 2015 the MSU will be forced to provide patient services to an increasing – and aging – population, with even fewer resources. Without a doubt the expense of maintaining an underused inpatient hospital represents a drain on financial resources that could be redirected to specialized outpatient, preventive, or follow-up care. It is the preliminary recommendation of this HSFMP that the MSU conduct a specific cost analysis to determine benefits / expenses of contracting all inpatient activities to local hospitals, consider discontinuing inpatient services of MIH, and channel resources to improved outpatient ambulatory care and prevention activities.

Planning Process

Tribal leaders were consulted regarding improvement to health care services and expansion of facilities in the process of researching and writing this HSFMP. As a part of the substantial outreach to tribal leaders each has been provided information regarding the major health issues of their specific tribe, significant data to assist each tribe as it plans its health care delivery system, community health education/outreach programs, and other services under the Indian Self-Determination Act.

From February to December 2004, the MSU Health Board, including tribal council members, IHS employees, and members of tribal health programs staff met to provide input to the HSFMP regarding the level of services desired by the year 2015, medical service priorities, and a core list of MSU Strengths, Weaknesses, Opportunities, and Threats (Appendix C). These documents help to form the basis for the HSFMP design and prioritization. A list of contacts and attendees from meetings are provided in Appendix D.

Service Unit administrative staff and tribal representatives reviewed and discussed use of the health facilities, including:

- the number of patient visits by categories of disease classification with historical perspective (Fiscal Years 1997 – 2003);
- provider workload based on these patient visits;
- pharmacy, laboratory, x-ray, dental, and medical visits;
- list of services currently provided by IHS and services that should be provided by 2015, based on tribal need;
- current and needed services in terms of “quality of care” and appropriate distance to obtain the service;
- services ranked in order of priority to assist tribal leaders and IHS administration to better understand critical needs; and
- Strengths, Weaknesses, Opportunities, Threats (SWOT presented in Appendix C).

In addition, interviews with key staff provided information regarding facility operating hours, current staffing levels and projected staffing needs for 2015, productivity and efficiency, and recommendations for improvements in provision of health services, administrative functions, equipment, and the physical facility. Questionnaire responses are included in matrix format in Appendix E.

Administration and medical staff were consulted regarding the disparity of statistics between two systems used by IHS for data reporting: the Resource and Patient Management System (RPMS) and the IHPES/ORYX databanks. In some cases, staff doubted the statistics from both data reporting systems because they seemed too low and unrepresentative of actual patient use. The consultants determined that the ORYX /IHPES reports were more reliable, had less duplication of data and had more “clean” data across all service units in the Albuquerque Area. The ORYX /IHPES database was therefore chosen as the source for analysis. A few exceptions are noted, and RPMS was included in the HSFMP to elaborate on specific issues.

Medical diagnostic statistics for the IHS user population of the Mescalero Apache Tribe were provided to tribal leaders. This included, for example, the number of living patients diagnosed with Diabetes Mellitus Type 2 and its complications as of July 1, 2004. Data were pulled from the IHS-RPMS database using specific search criteria within the Q-Man data system for International Codes of Diagnostics (ICD-9) of Diabetes Mellitus Type 2. Other data provided includes patient diagnoses of asthma, hypertension, cancer, heart disease, and high cholesterol.

This information was presented to help tribal leaders and medical staff analyze the level of need based on diagnosis, patient volume, and provider workload and to determine adequate care for current and future needs. Included in the HSFMP is a description of the existing Mescalero Hospital facility and its adequacy to meet current and future service demands. The HSFMP developed as a result of this process will assist the MSU and the Albuquerque Area IHS to determine primary care and specialty care needs as well as the facilities required to ‘house’ these services.

Findings: Health Services

The following findings and recommendations are the result of an 18-month planning process that included site visits, interviews with staff, and consultation with Health Board members and tribal leaders.

The number of patients registered at MSU rose by 34% -- from 6,589 in 1997 to 8,869 patients in 2004. MSU registers an average of 340 new patients each year. Registered users can also reflect one-time use of the facility by a patient from another region of the country traveling through Mescalero Apache Reservation and stopping for medical services.

IHS funding formulas and planning tools however, rely on the Active User Population which is substantially less. An Active User is defined as a patient who has interacted with any IHS facility across the United States at least once in the past three years.

The Mescalero Indian Hospital is primarily used as an ambulatory health clinic. In 2004, the MIH recorded a total of 33,831 outpatient visits, up by 13 percent from 2000 when the MIH recorded 29,830 outpatient visits. Historical data obtained from 2000 to 2004 and provided later in this document provides a snapshot of disease and use burden on the facilities of the MSU.

Overall, the MSU is struggling – as are most of the other Service Units -- to provide comprehensive patient care with decreasing financial resources. Congressional budget increases averaging 3percent per year cover mandated Cost of Living Adjustments (COLA), but are insufficient to replace equipment, hire new staff, or replace staff who have left. In fact, every Service Unit throughout the Albuquerque Area (and nationwide) depends on third party reimbursements to cover program, staffing, and equipment costs. As the number of registered and Active User patients grows, the number of inpatient admissions fell to only 208 in 204 while inpatient days at MIH dropped to only 626.

In 2004, the federal appropriation for MSU based on tribal shares and Resident Active User Population was $3,135,796 for staffing of the medical facilities, equipment, and facility management. Another $1.9 million was provided for CHS, while the tribe received $46,496 for its ISDA/638 mental health programs. It was supplemented by approximately $1.8 million from third party reimbursements. Almost of the 2004 MSU budget was funded from third party reimbursements. The chart below shows the increasing reliance of the MSU on Medicaid and Medicare reimbursements.

MSU Third Party Insurance Collections 1997 - 2004

MSU 3rd Party Insurance Collections	$ 1997	$ 2003	$ 2004	% Change 1997-2004	% of Total 2004
Private	46,701	68,016	63,326	36%	1%
Medicaid	199,585	1,411,383	1,496,081	650%	22%
Medicare	141,293	378,450	250,597	77%	4%
Other	-	19,592	1,379		0%
Subtotal 3rd Party Insurance	**387,579**	**1,877,441**	**1,811,383**	**367%**	**26%**
Federal Appropriations	3,976,004	4,889,921	5,063,262	27%	74%
Total	**4,363,583**		**6,874,645**	**58%**	**100%**

*Source: IHS budget data * Represents the entire appropriation including CHS, and minus mental health program ISDA/638 amount of $46,496.*

It must be noted that across the Albuquerque Area IHS depends upon third party reimbursements from Medicare, Medicaid, and private insurance for a significant percentage of its program and medical service support, and that percentage has been growing by double-digit numbers annually.

Since patients have the right to receive medical services at any facility that accepts their insurance, it is imperative that MSU begin to improve and market its services to attract new and retain existing patients. Threatened Medicare budget cuts may result in reduction of services for tribal members using outside medical care and encourage their return to IHS for health care. The same Medicare cuts would be felt by IHS, however, and it would be forced to provide additional services to tribal members with declining Medicare revenues.

Due to low funding levels, the IHS restricts patient care to Priority One medical conditions and thereby inhibits most preventive care and limits access to specialists. The Prioritization Schedule is provided in the Health Service Priority section of this Plan.

Continued use of MIH as an inpatient hospital is a high priority issue before the tribe. Tribal leadership feels continuation of the in-patient services is critical to provide appropriate culturally-sensitive care to tribal members who are uncomfortable with care in less sensitive local public and private sector hospitals. Tribal leaders view the provision of hospital services at Mescalero Indian Hospital as part of the federal trust responsibility to provide health care services for Indian people.

At the same time IHS is considering discontinuing inpatient services at the facility because usage rates are extremely low and the cost to maintain a severely underutilized service is draining resources from services that more desperately need attention. The facility experienced only 13% occupancy and slightly more than 1.7 in-patients as an average daily count in 2004. Losing accreditation as an in-patient hospital could jeopardize Medicare reimbursements for all MSU services, which are currently based on their designation as hospital-based clinical services. Should MIH cease in-patient services however, reimbursements for ambulatory service would drop by approximately 85% of their Medicare reimbursements.

A critical finding of this HSFMP is that medical recordkeeping throughout the Area-wide RPMS lacks standardization. Consultants found conflicting or inaccurate statistical reports on patient visits, provider workload, and facility use throughout the entire Albuquerque Area. Some statistical inaccuracies were due to poor data entry or recordkeeping by providers; other inaccuracies may have been due to poor data entry because of unreadable codes in charts. Chart reviews conducted by IHS area staff indicated that approximately 25% of data entry may be suspect. Since the IHPES data are used to provide reports for providers and patients, this statistical omission indicates a problem exists.

Reporting of poor or inadequate statistics can create funding formula problems and lead to inadequate medical service delivery within Mescalero Service Unit. Poor statistics affect formulas used for program funding and staff positions; they also affect health care delivery when used for planning and implementation of health services. Discovery of these statistical problems early in the HSFMP process encouraged Albuquerque Area IHS to develop standardized coding protocols and staff training curriculum to improve data entry. This training was implemented in late 2004, and results should be noticeable by late 2005.

Complicating the issue of coding and statistics is the IHS practice to convert specific ICD-9 codes into more general disease codes in the RPMS system. For example, an IHS medical records clerk will enter any of the ten ICD-9 codes used to describe varying conditions for Diabetes Mellitis Type II as the one diagnostic code (080)—also known as “APC”—which defines Diabetes Mellitis.

Moreover, the IHS/APC codes are so generalized that they can mask the extent of and complications associated with a disease category. For example, no IHS code exists for “Asthma” even though a search using the ICD-9 codes in the Q-Man data of the RPMS system shows that as of 239 Mescalero tribal members and 99 “others” who utilize the MIH were diagnosed with Asthma as of July 1, 2004. Instead, the IHS codes refer to conditions such as “upper respiratory infection’, or “acute bronchitis” or “chronic bronchitis” or “respiratory disorder”.

Comparison between the IHS/APC and ICD-9 systems is difficult and virtually impossible without a "key" to decipher the codes. The use of IHS/APC coding is confusing, duplicative, and unnecessary.

The Albuquerque Area Diabetes "Datamart" Project conducted random chart reviews of approximately 35% of the Albuquerque Area known patients with diabetes. It found that the datasets from RPMS contain one record per encounter, per client. Clients can have multiple encounters on a single date. Clients are identified at the encounter by two fields: ASUFAC (area/service unit/facility code) and HRN (Health Record Number). Problems were noted because a single client may not have the same values for these fields on all records. The ASUFAC can change because the client was seen at different facilities or because the codes for ASUFACs are changed in the IHS system. HRNs may change because they are assigned at the facility or service unit level. Social Security Numbers (SSNs) recorded on these records can help identify patients but some records do not have SSNs, and others contain data entry errors that result in incorrect SSNs for patients.

Further complicating the consistency of data for statistical purposes is the data recorded by tribal contract and compact programs such as Substance Abuse, Diabetes, and Community Health Representatives. The problem is pronounced when this data is not shared with IHS nor entered to the RPMS system. It is virtually impossible to tally the number of patients seen at MSU who are diagnosed with substance abuse, since substance abuse patients usually interact with the medical system only when prompted by another condition, which then takes precedence and is recorded by diagnostic code.

Both data collection systems, RPMS and IHPES/ORYX are flawed due to inconsistent data entry; however, it was decided through the HSFMP planning process that the IHPES/ORYX data was more reliable and should be used as the basis for facility planning. It is used throughout all Area Plans except where noted otherwise.

For example the RPMS system showed that MIH reported 214 discharges in FY 2004 with a total of 691 inpatient days. For the same time period the IHPES system reported 208 discharges and a total of 626 inpatient days. The consultants could identify no reasons for the data discrepancy.

Unfortunately, the IHS data – whether it is RPMS or the IHPES databank -- is all that is available for planning purposes. Wherever possible, data analysis is adjusted for conditions that may have affected patient volume, such as long-term loss of a medical provider.

Other significant findings include:

1. Recordkeeping

The quality and consistency of recordkeeping and data entry may vary by service provider, resulting in inaccurate statistics. In fact, inconsistent use of provider codes resulted in large variations in provider data by facility, with consultants finding that no consistent use or definition of "Family Practice", "General Medicine" and other titles existed between Service Units.

a. Statistical reliability varied by department within MSU and showed even greater variability between the nine service units of the Albuquerque Area.

b. Poor recordkeeping by health care providers or medical records documentation negatively influences statistics and funding.

c. Poor recordkeeping may inaccurately indicate a reduction in service need.

d. A reduction in the number of patient visits for a particular health service may be the result of service interruption due to staff shortage or budget restraints; it could also be the result of poor data entry. It may not reflect the actual need.

e. Lack of patient data/communication between MIH and tribal programs, most importantly the Community Health Representatives (CHRs) is compounded by staff interpretation Health Insurance Portability & Accountability Act of 1996 (HIPAA) rules. The issue is further compounded when a patient receives services at another hospital or medical clinic and then returns to MIH for follow-up care. Poor communication has resulted in inconsistent data that do not record laboratory, pharmacy or care provided to a patient moving from one facility to another, placing patients and providers at risk of inaccurate information and poor medical care.

2. Migration of Urban Indians

IHS does not have a mechanism for reimbursing cost of care for "Urban" Indian patients who receive care at a facility that is not located in their home service unit. In 2004, approximately 23% of patients in the MSU were "Urban" Indians. Although some of these patients may be eligible for Medicare and/or Medicaid insurance, many are not.

3. Reduction of In-Patient Care

Since experiencing a "peak" of inpatient services in 1997 MIH has seen a reduction in admissions/discharges, as well as in services provided and the number of providers. The average daily count (ADC) fell from 3.2 patients in 1997 to 1.7 in 2004 – extremely low by any hospital industry standard for a viable in-patient facility. The average length of stay (ALOS) for an in-patient dropped from 3.7 days to 3.0 days – more in keeping with industry standards that are responding to limited insurance coverage for longer in-patient care.

Overall occupancy rates fell from 24% or 1,158 patient days/year in 1997, to only 13% or 626 days/year in 2004. Inpatient statistics for MIH are included on page 31.

In April 2003 the MIH closed its Emergency Room operation of 24 hours / day 7 days / week when the number of patients using the service fell to almost zero. It was replaced by "Urgent Care Plus" which provides urgent care at reduced hours, from 8 a.m. – 10 p.m. Monday through Friday, and from 8 a.m. to noon on Saturday, Sunday, and holidays. Walk-in patent seen at MIH after normal ambulatory care hours were logged as "emergency room" visits and so at one point the patient care numbers reflected a higher than normal emergency room burden. This practice was discontinued in Fiscal Year 2005.

Given the reduction in hospital operating hours this HSFMP has considered that patient usage of the facility since 2002 may have fallen due to reduced hours. On the other hand the reduction in hours was partly due to a reduction in usage which is indicated by a 34% drop in the number of admissions/discharges, and 46% drop in daily count.

The expense of maintaining an underused inpatient hospital, however, represents a drain on financial resources that could be redirected to specialized outpatient, preventive, or follow-up care.

4. Contract Health Services

A review of CHS expenditures indicates that the MSU Contract Health Service budget grew by 26% between 1997 and 2003. Of the total spent, funding for hospitalizations grew by 51% from 1997 to 2003; non-hospital service grew by 20%, and CHS dental care decreased by 83%. More detailed information is provided starting on page 44. Considering that in-patient care has decreased substantially at MIH while CHS expenditures for hospitalization increased, it is worth considering whether in-patient care was shipped out while it could be provided within the MIH facility if adequate space and providers were available.

Lack of access to certain medical specialties (e.g., podiatry, orthodontry) within the IHS service delivery system means that these providers can only be used by referral through the CHS system, which is controlled by Priority One status and reviewed by the MSU administration. This has resulted in patients receiving inadequate preventive care and in ultimately higher long-term health care costs. Long appointment wait times for some dental services and limited appointments for specialized care (e.g., podiatry, orthodontry) provided through Visiting Professionals or CHS dollars restrict access to services that are critical for certain preventive care outcomes and negatively impact the quality of care as well as patient health.

5. Equipment

Throughout site visits and as a result of staff interviews, the consultants found a high percentage of old (over 20 years old) equipment within ambulatory medical, dental and optometry clinics. While staff tries to "make do with less," patients are not convinced that this approach yields the highest quality care available. In fact, some staff noted that the older equipment is a deterrent to young medical providers who are trained on newer equipment and feel that using older equipment will degrade their skills. Limited or nonexistent budgets to replace old equipment, difficulties in repairing old/outdated equipment, and the resulting competition among departments to justify the purchase of new or replacement equipment will continue to have a negative impact on the quality of care within the next year and well into the future.

6. Limited Prevention and Education Activities Impact Health Status

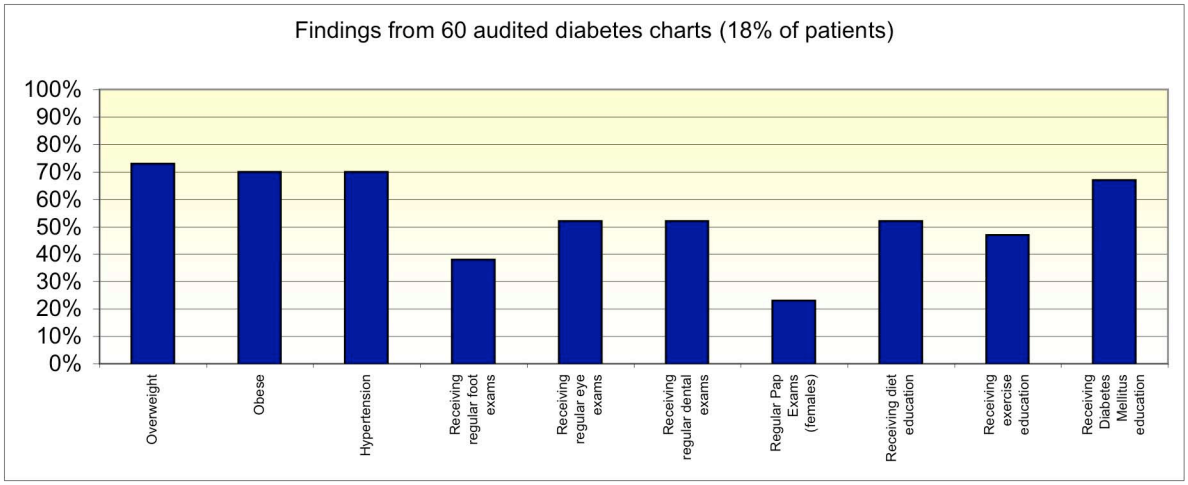
Tribal leaders expressed concern that lack of preventive care, education, and outreach has negatively impacted the health status of their communities. Clinic staff initiated a School Based Health Clinic Survey for 500 students at the Mescalero Apache School; 137 surveys were returned by parents. Of the results, 22% indicated that Transportation presented a problem in accessing or receiving health care, while 80% indicated a need for a school based health clinic. The "Journey to Wellness M.Y.W.A.Y." program identified health concerns, strategies, goals and activities to have a positive effect on community health.

To date the program has held Health Fairs and community outreach activities to reach out to the community. While this program is making some headway in the community, a general lack of coordination between programs that the tribe has taken control of through the Indian Self-Determination Act, and the medical and program staff of MSU is a problem that leads to poor quality of prevention and outreach activities. Although tribes that choose to exercise Self Determination contracts for some programs such as diabetes have control over their program activities, experience in other IHS Service Units shows greatly improved results when tribal staff –who are usually not medically trained – are strongly supported by and even integrated with medical providers and IHS staff.

7. Meeting IHS Standards of Care

The Albuquerque Area's Diabetes Project Audit of diabetes charts in 2003 revealed the following information. Of the 332 diabetes charts in the registry, 60 were audited (18 percent). The chart below indicates results of the chart audits. IHS' Standards of Care for Diabetes Mellitus are listed later in this document.

Diabetes Audit Chart



8. Staff Recruitment and Training

In some cases, hiring freezes implemented through reduced budgets prohibit use of on-going federal funds to hire staff. Some medical providers indicated that staff recruitment and retention is a problem. Finally, New Mexico itself experiences a lack of licensed specialty physicians, nurses, dentists, and other providers, making recruitment and retention in rural locations such as Mescalero, a true challenge. In some cases, MSU has no alternative than to provide necessary services through contracted employees, or through CHS expenditures because they simply cannot get qualified applicants for vacant positions.

9. Pharmacy

The medical staff and administration anticipate an increase in pharmacy services as the number of prescriptions and need for prescription management increase, reflecting changing Standards of Care throughout the medical industry. There is a growing demand for prescription clinics for both medical providers and patients, to better understand drug interactions and appropriate pharmaceutical choices. The MIH pharmacy has adequate work space although no private consultation space for dispensing prescriptions.

Patients are counseled at a semi-open doorway; consultants observed patient consultation at the pharmaceutical window, within earshot of other patients who were standing in the hallway waiting for ambulatory care. One very small pharmacy office space is shared among providers, with 2 computer terminals, one of which is owned by the drug wholesaler and is dedicated to pharmacy software and outpatient dispensing software. The pharmacy lost space in 2002 when open space was converted to a small office; now there is a shortage of drug storage capacity.

10. Transportation

Transportation to / from MIH is a problem for individuals without a car. Although the Mescalero Apache tribe has an agreement with Alamogordo to provide transportation "Z-Transporation" services to /from the reservation facilities for only $1 / ride, the bus stops running at 6 pm and does not operate on weekends or holidays. Patients have been stuck at the hospital after-hours because they cannot get a ride home.

11. "No-Show" appointments.

Depending on the medical provider, the ambulatory medical clinic at MIH experiences 30-40% (average 35) percent 'no-show' rate for scheduled appointments for primary care AND specialist appointments. Dental services report a 16% percent no-show rate while Optometry reports a no show rate of 30 percent. Public health nurses estimate a 30-50 percent now show rate, while Mental health providers report an average no-show rate of 25 percent and substance abuse appointments may be much higher because people are referred from the Emergency Room or Urgent Care, many times without request. Schedulers often 'depend' on this high rate and will double or triple book appointments, affecting provider productivity, room / space utilization, waiting times and patient services if the original appointment shows up. At the same time the number of 'walk-in' patients is on the rise, probably because people understand that they can more quickly access medical care by showing up at the clinic than waiting for an appointment. It has also been suggested that a high turnover of medical staff contributes to lack of trust, and therefore higher 'no show' rates.

12. Long Wait Times

Poor patient flow through an awkward floorplan (originally designed to function primarily as a hospital), not enough examination rooms, and scattered offices for providers means that patients' wait time for a scheduled primary care examination can be 30-45 minutes; walk-in patients can expect to wait about 75 minutes. Patients will usually receive triage attention within 10 minutes of registration, but must wait up to 30 minutes in a crowded waiting room for laboratory tests, and / or xrays. They can expect a 30-45 wait for an examination room to open and then 15-30 minute wait for pharmacy to get the chart and fill the prescription. Dental appointments have been back-logged for almost two years so the dental staff reserve a high percentage of time each day to handle 'emergency' cases, but patients often wait up to 3 hours for 'emergency' treatment.

Recommendations: Health Services

1. Improved Data Quality

- Standardize data entry, medical records, coding of provider services, etc.
- Eliminate use of IHS/APC codes and practices that congregate ICD-9 codes into nonstandard medical categories.
- Expedite installation of Electronic Health Records to facilitate flow of patient data between clinics and provide improved medical care with less risk to patient and provider.
- Obtain funding for use of Palm Pilots to improve data entry especially for field providers, public health nurses and community-based educators.

2. Health Care Coverage

Work with other Area offices, national IHS and the U.S. Congress to adopt nationwide healthcare system that will require reimbursement to Service Units for Urban Indian patient care. In essence, the dollar follows the patient and is not automatically sent back to the home service unit.

3. Expansion of Outpatient Services & Community Clinics

a. Ambulatory medical services are provided at the Mescalero Indian Hospital during a standard 8 a.m. – 5 p.m., Monday through Friday and 1 pm – 5 pm on Saturdays. Evening care is provided through Urgent Care Plus from 5 p.m. through 10 p.m, Monday through Friday and Saturday morning. A market study should be engaged to explore the possibility of expanding services to include evening clinics to reduce the number of patients using emergency room services at MIH and at area public and private hospitals and reduce overall expenditures for CHS.

b. Regionalize or consolidate supplies and pharmaceutical drug purchasing throughout the Albuquerque Area to reduce costs and allow pharmacists to conduct community clinics to expand patient education and outreach.

c. Expand medical detoxification for substance abuse patients. The Mescalero Apache tribe has elected to provide substance abuse program/counseling services through ISDA contracts. It may be possible that MSU could develop a marketing plan to include all Albuquerque Area tribes buying buy back services from MSU for a detoxification unit.

d. Develop “mobile clinics” that would work with the tribe’s CHR program to go into the community and provide “clinics in a suitcase” for high-volume diagnoses categories including podiatry and diabetes. The Tohono’o’dom Tribe in Arizona has experienced significant improvements in tribal members’ health and a drastic reduction in the number of lower limb amputations since such a process was instituted.

4. Maximize third Party Health Insurance Collections

The Mescalero Tribe contracts with Blue Cross of New Mexico to provide medical insurance to employees. The program however, does not allow IHS to bill Blue Cross for services provided to tribal members that use the facility. As a result insured tribal members who use the IHS facility and are referred to specialty care represent a drain on MIH resources when the insurance company cannot be billed for reimbursement for services.

5. Outreach Activities

a. Expand prevention activities for high-risk individuals and patients that fall within major disease categories.

1) Most tribal staff do not have extensive medical training; providing support and partnership with MIH medical providers would improve program outcomes.
2) MIH could act as regional "case managers" to follow patient care, integrate treatment planning, and improve overall coverage for patients, including care provided through CHS expenditures to area hospitals and CHS referrals.

b. Improve communications, training opportunities, and cooperation between medical staff, administration, and tribal programs, especially with diabetes, substance abuse, and mental health services.

c. Develop Memoranda of Understanding between IHS MSU, Bureau of Indian Affairs, and the tribal programs to reduce duplication of services and channel needed funds into creating a regional tribal Detoxification Center and prevention programs.

d. Increase the number of patient liaison/patient advocate positions for follow-up care after in-patient care at area hospitals and MIH.

e. Develop a physician-in-residence at Alamogordo and Ruidoso Hospitals so that IHS physicians visit patients admitted for in-patient care and ensure a smooth transition back to IHS care.

f. Institute a system of "Appointment Reminder Calls" for patients to reduce the number of 'no-show' appointments for regular ambulatory clinics and specialty /visiting professional clinics, thereby improving provider productivity and patient care.

6. Transportation

Develop transportation service from distant communities such as Alamogordo, Ruidoso, and Carizzozo to MIH for Medicare/Medicaid patients to replace the private-sector transportation programs now used by many patients without vehicles. MSU would receive reimbursement for transportation services, and provide patients with a much-needed service.

7. Continuum of Care

Expand home health care services. Public Health nurses do not bill Medicare for home health because this is not an eligible activity. However, MIH could create a home health care department and expand this service.

8. Podiatrist on Staff (shared with other Service Units)

Experience at other Service Units and other IHS Areas indicate that using third party reimbursements or diabetes grant monies to hire a part- or full-time podiatrist has significantly reduced the number of lower limb amputations and improved overall health of diabetes patients. It is an irony of IHS that amputations are an approved health care cost, but podiatry and foot care are not high priorities.

9. Create a Mescalero Indian Hospital Foundation

Incorporating the Mescalero Health Board as a not-for-profit 501(c)3 organization would allow it to more easily raise funds for programs, staff, equipment, training, and other activities. Whether the Health Board or another entity assumes leadership of a Foundation, it is an important additional source of funds that practically every private hospital in America has discovered.

10. Expedite Installation of Teleradiology and Telemedicine

Expand teleradiology practices at MIH; expand telemedicine technology to community clinics, and enter into contracts with universities or hospitals capable of providing services unavailable within the Albuquerque Area. The MIH is one of three pilot sites within the Albuquerque Area IHS to develop the infrastructure and initiate teleradiology activities. The IHS' Radiologist stationed at the Albuquerque Service Unit will read the X-Rays and respond to MSU needs. Converting existing equipment to function with teleradiology technology costs approximately $175,000. The addition of telemedicine technology would provide video conferencing for real-time collaborative medical education, training, remote consultation, and emergency response. The benefits include: reduction in patient transportation time and cost; a real-time second opinion; enables quicker patient diagnosis; and access to resources for continuing medical education. The MSU could pursue funding opportunities through the Department of Health and Human Services as well as private foundations to pay for this expense.

Findings: Facilities

The IHS has developed a Healthcare Facilities Construction Priority System (HFCPS) which reviews and evaluates all IHS-operated medical facilities. The Facilities Needs Assessment Workgroup and the Facilities Appropriation Advisory Board (FAAB) have developed and reviewed evaluation criteria that provide methodology for this priority-setting activity. The HFCPS will incorporate findings from the Health Services and Facilities Master Plans to rank healthcare facilities construction and renovation needs.

IHS uses a Supportable Space Formula to determine required space, using a standardized formula which was developed and applied to estimate the space that IHS supports for allocation of Maintenance and Improvement Funds. This method does not account for the demographics of the user population.

A second method uses the Base Health Systems Planning (HSP) Software to provide a more detailed measure of the facility needs, based upon demographics of the served.

The Federal Engineering Deficiency System (FEDS) categorizes the deficiencies that require repair or renovation and provides cost estimates to address the identified deficiencies. Deficiencies noted on the MIH Facility Sheet on page 31 are estimates and may need to be changed.

1. Facility Design and Adequacy to Meet Service Need

a. The existing MIH facility was originally designed as an in-patient facility with ambulatory medical services but now functions primarily as an ambulatory clinic.

b. The building size is inadequate to meet service and provider space needs for current use; it is only 1/6th of the size needed to meet projected space needs in the year 2015.

c. The building design is inadequate as an ambulatory clinic and inhibits productivity of providers, limits expansion of necessary or desired services, and results in a clumsy patient flow.

d. Decreased in-patient activity results in under use of valuable space that might otherwise be used as ambulatory clinic space.

e. In-patient rooms converted to ambulatory clinic examination rooms are very large for the purpose and represent “wasted” square footage.

2. MIH Equipment

Staff reported equipment shortages, computer failures, and lack of phone, fax lines, and conveniently located copy machines that inhibit productivity. In some cases (dentist) the closest fax machine is located across the building, prohibiting confidentiality and efficient use of time in sending / receiving faxes. Other equipment needs include:

- XRay equipment is old and needs to be upgraded to provide adequate diagnostics for the patient load.
- Upgraded or new computers for all administrative staff; some new printers, computer networking systems, cabling, server.
- Paper shredders
- New copy machines
- A new lab-stainer to provider adequate diagnostics
- A new tomometer for optometry
- New visual field analyzer
- New patient chair in optometry
- New Stand unit in optometry
- Cardiac monitors
- New fetal monitor
- Changing IV infusion pumps
- Updated Blood pressure monitors

3. Patient Registration

Patient registration is without confidentiality. Meetings with benefits coordinator in the front office also lack confidentiality. Registration takes place at two cubicles that sit within 10 feet of the MIH entrance door while patients waiting to register will line up directly behind the registration desk, within 3-5 feet. Registration staff sit in a cramped room that is far undersized for its purpose. Staff have inadequate space for filing, supplies, fax or copier machine, and the ventilation system is inadequate. Equipment requested by staff include a copier, paper shredder, and upgraded computers.

4. Medical Records

Space is inadequate to meet staffing need; the office is cramped and files are piled high because filing and storage space is needed.

5. Waiting Areas

The existing first floor waiting room is too small and overflows regularly, with patients spilling into the hallways and compromising confidentiality at the registration desk and the pharmacy. Patients who wait to see providers on the converted second floor inpatient unit sit in chairs that line the hallway.

6. Storage Space

Throughout the hospital storage space is at a minimum and is often located far from the space where it is needed. Secured storage for confidential records and valuable equipment is also inadequate.

7. Dental

Dentists have no room for private consultation or for storage of supplies. The dentist shares one small office with dental technicians, which also doubles as storage space.

8. Staff Lounge

There is no staff lounge. Staff now use either the 2nd floor conference room or a small space that doubles as a storage room is often used by staff to eat lunch or take breaks.

9. Staff meeting / training / education

The staff commonly meet in the 1st floor waiting room or in the 2nd floor conference room. Neither space is adequate to hold even 50% of the existing staff. No facilities exist for mandatory staff training or education seminars.

10. Signage

Inadequate signage throughout the hospital and between buildings leaves patients and especially visitors, slightly confused about administrative office location or services.

11. Contract Health Services

One office space is shared by three staff who are responsible for interviewing and counseling patients about eligibility benefits and making appointments with the referral agencies. Patient confidentiality is compromised. File storage space is inadequate, and confidential records are compromised.

Recommendations: Facilities

1. Facility Improvements to Meet Service Need

a. Renovate the MIH to accommodate improved data lines for information technology and telemedicine.

b. Renovate the MIH facility to better accommodate ambulatory patient flow and increase the number of outpatient/examination rooms.

c. Renovations needed include additional staff meeting and education rooms, employee wellness facilities, and provide additional lockers for employees.

2. Explore Joint Partnership Agreement with Federal Government

In 2007 it is anticipated that Congress will approve another round of Joint Partnership Agreements (JPA) to match a tribe's investment to construct a facility, with guaranteed funding for the administrative and medical staff by the federal government to meet the needs of the service unit.

3. Alternative Uses for In-patient

Medical Detoxification – Explore the use of MIH for long-term care for medical detoxification of MSU and/or Area-wide tribal members.

4. Facility Improvements by Department to Meet Service Need

Based on site visits and staff interviews

a. Expand pharmacy storage and provide patient consultation rooms.

b. Expand laboratory space to provide more efficient administrative space and technician work.

c. Group education rooms for diabetes, obesity, hypertension, etc.

d. Expand storage capacity for confidential records, supplies and equipment.

e. Designate a specific area for providers to work on charts so that they are not scrambling for space or seats.

f. Update computer software. Most (all?) systems still operating with Windows 98 software.

g. Improve security.

h. Provide separate facilities or room for wound care.

i. Create a kids play area so the children aren't running through hallways and have some activities to keep them occupied.

j. Overall building renovation to restructure patient flow and improve administrative efficiency. For example, consider moving administration offices to 2nd floor; remodel entire first floor to outpatient clinics.

Demographics and Physiographic Features of the Area

Service Unit Boundaries

The existing administrative Service Unit boundaries of the Mescalero Apache Reservation, located in portions of Chavez, Lincoln and Otero Counties of southeastern New Mexico, have been used in this report. MSU has responsibility for providing access to inpatient facilities and medical services within 90 minutes (approximately 95 kilometers) driving time, for patients registered with the Mescalero Apache Nation. Access to outpatient facilities is based on a 30 minute (30 kilometer) standard. The time/distance IHS standards for health centers and inpatient facilities are met throughout MSU.

There is a significant migratory pattern that indicates how members of other tribes use the MIH and facilities within the overall Albuquerque Area IHS system. This pattern also shows use of each facility by Urban Indians (see Appendix M).

The MSU Active User population and projected user population are presented below, comparing these numbers to the U.S. Census population (year 2000) and the tribes' own enrollment numbers.

MSU Active & Projected User Population

Tribe / Service Unit	2000 Census (NM)	*2000 Tribal Population*	2004 Active User Population*	2015 Projected Active User Population	% Active User Population Growth 00 -15
Other/Urban	848		**840**	1025	22%
Mescalero	3180	*4167*	**3607**	4401	22%
MSU Total	**4028**		**4447**	5147	**22%**

** Taken from U.S. Census and IHS Percentage of Urban Indians in Residence*

Based on Active User population, the Mescalero Tribe is relatively young, although statistics show that the population is aging. The average age of the MSU Active User population is 26 years, while 31% of patient visits are from individuals over 45 years of age and patient visits from the 45 + age group have grown by 33% over the previous five years. Patient visits from the 65+ age group alone have increased by almost 45% in five years. The chart below outlines patient visits to MSU by age. As the 'bubble' population in the 15-44 range ages, MSU services and facilities will obviously need to change to accommodate more prevention and disease categories that affect this group.

Mescalero Service Unit Total Outpatient Visits by Age 2000 - 2004

Age	2000	2001	2002	2003	2004	2004 % of Total
0-1	1449	1279	1367	1171	1000	3%
1 – 14	7542	6676	7323	6290	6926	20%
15 – 44	13,896	14,669	16,503	16,368	15,518	46%
45 – 64	5531	5890	7022	8214	7817	23%
65 +	1412	1804	1853	2586	2570	8%
Totals	29,830	31,318	34,068	34,629	33,831	100%

Source: IHS/IHPES.

Service Unit Location

The MSU has responsibility for providing access to inpatient facilities and medical services within 90 minutes (90 miles or approximately 145 kilometers) driving time, for patients enrolled in the Mescalero Apache Nation. Access to outpatient facilities is based on a 30-minute (48-kilometer) standard. The time/distance IHS standards for health centers and inpatient facilities are met throughout MSU.

Facilities in Ruidoso, NM, Alamogordo, NM, Las Cruces, NM, El Paso, TX, Lubbock, TX and Albuquerque, NM provide alternative referral sites for patients throughout MSU. The distance to the Mescalero Indian Hospital and other potential medical providers is listed below and in Appendix G.

Distance To Clinics / Hospitals From Key MSU Communities

	DISTANCE TO				
MSU Community	**Mescalero Hospital**	**Ruidoso Clinics / Hospitals**	**Alamogordo Clinics / Hospitals**	**Las Cruces Clinics/ Hospitals**	**Albuquerque Clinics/ Hospitals**
Mescalero	0 miles	16	28	97	213
Ruidoso	16	0	48	116	183
Alamogordo	28	48	0	68	209
Carizozzo	12	5	225	109	225

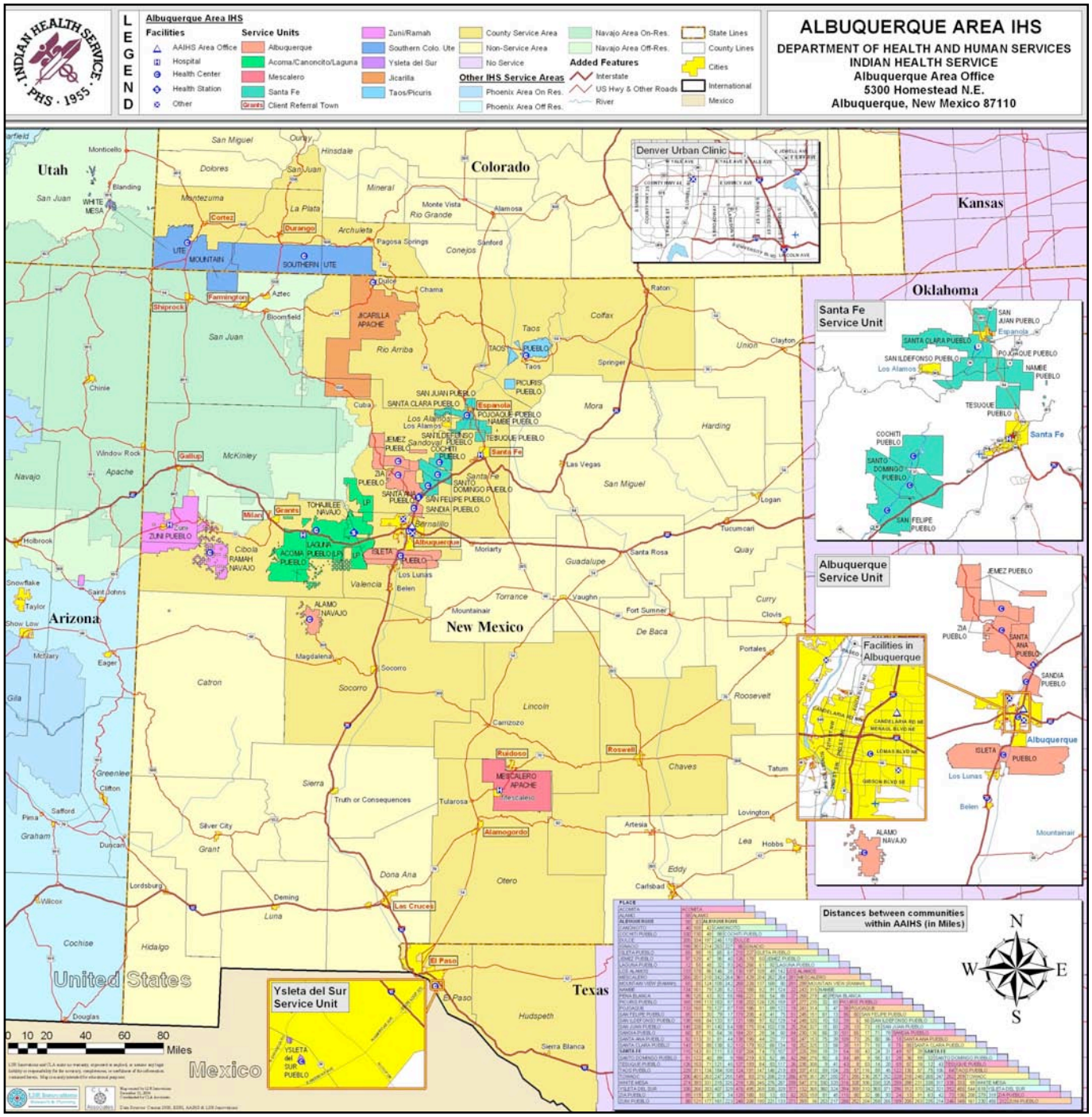
Distance Between Communities within AAIHS

Distances between communities within AAIHS (in Miles)

PLACE	ACOMITA	ALAMO	ALBUQUERQUE	CANONCITO	COCHITI PUEBLO	DULCE	IGNACIO	ISLETA PUEBLO	JEMEZ PUEBLO	LAGUNA PUEBLO	LOS ALAMOS	MESCALERO	MOUNTAIN VIEW (RAMAH)	NAMBE	PENA BLANCA	PICURIS PUEBLO	POJOAQUE	SAN FELIPE PUEBLO	SAN ILDEFONSO PUEBLO	SAN JUAN PUEBLO	SANDIA PUEBLO	SANTA ANA PUEBLO	SANTA CLARA PUEBLO	SANTA FE	SANTO DOMINGO PUEBLO	TESUQUE PUEBLO	TAOS PUEBLO	TOWAOC	WHITE MESA	YSLETA DEL SUR	ZIA PUEBLO	ZUNI PUEBLO
ACOMITA																															
ALAMO	58																														
ALBUQUERQUE	58	83																													
CANONCITO	40	105	42																												
COCHITI PUEBLO	100	130	48	98																											
DULCE	205	334	197	246	170																										
IGNACIO	199	351	214	263	227	86																									
ISLETA PUEBLO	65	98	15	65	61	210	227																								
JEMEZ PUEBLO	97	129	47	96	40	126	178	60																							
LAGUNA PUEBLO	12	55	48	32	93	242	266	61	92																						
LOS ALAMOS	133	178	96	146	35	130	197	109	49	142																					
MESCALERO	265	201	218	342	264	361	429	204	262	264	261																				
MOUNTAIN VIEW (RAMAH)	65	85	124	108	242	268	228	137	168	80	291	299																			
NAMBE	134	161	79	128	52	122	188	92	91	124	22	243	315																		
PENA BLANCA	96	125	43	92	55	166	221	56	54	88	37	258	279	48																	
PICURIS PUEBLO	165	195	113	163	87	135	202	126	125	159	37	277	235	32	83																
POJOAQUE	133	160	78	127	87	119	186	91	89	123	19	241	314	3	47	36															
SAN FELIPE PUEBLO	85	111	30	79	17	179	208	43	41	75	51	245	151	61	13	96	60														
SAN ILDEFONSO PUEBLO	138	166	84	133	57	121	188	97	62	129	14	248	320	10	53	39	6	66													
SAN JUAN PUEBLO	145	228	91	140	64	108	175	104	102	136	25	254	327	15	60	28	13	73	15												
SANDIA PUEBLO	68	97	15	64	36	184	201	28	34	60	84	230	136	66	30	101	65	17	71	78											
SANTA ANA PUEBLO	82	113	31	81	44	138	190	44	23	77	92	247	153	75	39	109	73	25	80	86	18										
SANTA CLARA PUEBLO	143	170	88	138	62	112	179	102	66	134	18	252	325	13	58	35	11	71	10	8	76	85									
SANTA FE	115	143	61	111	63	137	204	74	73	107	37	225	298	19	31	54	18	43	24	31	49	57	29								
SANTO DOMINGO PUEBLO	91	122	40	89	9	168	219	53	52	85	42	256	276	50	6	84	49	9	55	61	28	36	59	32							
TESUQUE PUEBLO	126	153	71	121	45	127	193	84	83	117	26	235	308	9	41	43	8	53	14	20	59	67	18	12	43						
TAOS PUEBLO	229	311	134	184	108	124	191	147	146	219	69	337	410	59	104	25	57	116	59	45	122	130	57	75	106	64					
TOWAOC	206	401	263	247	255	149	83	276	206	219	266	479	351	257	250	271	255	236	257	252	229	218	248	268	247	262	259				
WHITE MESA	274	393	331	315	325	219	128	345	276	287	339	547	376	330	320	316	328	306	330	325	299	288	231	338	317	335	333	59			
YSLETA DEL SUR	336	266	283	407	329	478	495	269	328	329	377	132	365	360	324	394	359	310	365	371	296	312	370	342	321	352	455	544	618		
ZIA PUEBLO	89	119	37	87	34	129	180	50	13	83	62	253	159	81	45	115	80	32	86	93	24	13	91	63	42	73	136	208	279	319	
ZUNI PUEBLO	88	121	177	161	223	248	208	190	221	133	271	393	36	253	217	288	252	204	258	265	189	205	263	235	214	246	348	161	230	458	212

This map indicates the boundaries of the Albuquerque Area IHS. It identifies each Service Unit, the tribes within that Service Unit, and the type of medical facilities available at within each Service Unit.

AAIHS Service Unit Map



Existing Location and Health Services Provided

Medical services for the MSU are provided through one IHS-owned and -operated hospital/clinic/dental facility located in Mescalero.

MSU IH Facility Sheet

Mescalero Indian Hospital

SERVICES PROVIDED

Outpatient	Dietary
Inpatient	Audiology
Dental	Physical Therapy
Optometry	Emergency Room/ Urgent Care
Pharmacy	EMS/Transport
RadiologyLaboratory	
Mental Health	

FACILITY DATA

Installation Number	11514
Year Built	1968
City, State	New Mexico
County	Otero, Lincoln
IHS Owned/Leased?	IHS-owned
Distance to Service Unit Office	N/A
2005 Total Square Footage w/ inpatient	52,392
2015 Projected Need (no inpatient)	73,530
# of Buildings	17
# of Housing Quarters	11
# of Licensed Hospital Beds	13
# of Staffed Hospital Beds	11
# of Exam Rooms	11
2004 Staff Positions	91
2015 Projected Staff Need (no Inpatient)	168

PRIORITY ISSUES

Facility Deficiencies:

Safety	$5,840
Compliance	$102,037
Plant Management	$1,250
Maintenance & Repair	$505,377
TOTAL	**$614,504**

Board Priorities:

1. Ground Ambulance
2. Transportation
3. Gynecology Services
4. Home Health
5. Dental and Pediatric Dental

Staff Priorities:

Based on interview matrix and staff prioritization process.

User Population	1997	2004	2015 (projected)
Mescalero Tribal Members	3,280	3,607	4401
Non-Service Unit Tribal Members	772	840	1025
Total User Population	4,052	4,447	5,147
Annual Outpatient / Ambulatory Patients	25,535	33,831	50,400
Average Daily Inpatient Load	3.2	1.7	0

Health Services Delivery Plan

Mescalero Hospital Inpatient Summary 1997-2004

	Year								% Change
DATA	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**1997-2004**
Licensed Beds	13	13	13	13	13	13	13	13	0%
Discharges	317	341	319	437	283	244	191	208	-34%
Days	1,158	1,110	1,243	1,313	789	615	537	626	-46%
Occupancy	24%	23%	26%	28%	17%	13%	11%	13%	-46
ADC	3.2	3.0	3.4	3.6	2.2	1.7	1.5	1.7	-46%
ALOS	3.7	3.3	3.9	3.0	2.8	2.5	2.8	3.0	-18%
Newborn Days	0	0	0	0	0	0	0	0	
Births	0	0	0	0	0	0	0	0	

Data source: IHS/IHPES.

Inpatient Care

It is obvious from the numbers shown above that inpatient activity at MH is decreasing. While the hospital industry nationwide has experienced a reduction in Average Length of Stay (ALOS) in response to insurance changes, the MIH has had a considerable reduction in the Average Daily Count (ADC) and number of admissions/ discharges from 1997 to 2004. A corresponding increase in the number of MSU patients admitted to area hospitals would indicate that the MIH experienced a problem with its ability to provide care for in-patients during this time period.

Discharge volume has declined by 34% in seven years, and the occupancy level was only 13% in 2004. By most health planning standards, this is a struggling enterprise at best and it represents a drain on limited resources that could be used to provide better ambulatory care to patients.

As a result of decreased inpatient and ambulatory services due to Priority One service designations, Contract Health Service dollars are being used to make up for the deficiencies of the health services not provided within IHS facilities. Therefore, it may be impossible to reasonably project CHS needs by the year 2015. In addition, use of CHS dollars to pay for care is not a clear measurement of health care service need, nor is it an adequate measurement of the ability of the Service Unit to provide health care, within its budget allocation. By limiting patient referrals and access to health care, the IHS is only delaying the inevitable backwash of medical problems that result from failing to address primary or preventive care now.

MSU continues to use contract inpatient services for acute, specialty, and sub-specialty care that are not provided directly at the MIH. These services include:

- Acute psychiatric care
- Breast tissue Biopsy
- Bone marrow transplant
- Burn unit treatment
- Dialysis
- Cancer diagnosis and treatment
- Cardiology
- Day Surgery
- Chemotherapy/radiation
- Critical spinal care
- CT scan
- Ear/nose/throat surgery
- Gynecology surgery
- Intensive care
- Long-term care
- Neurosurgery
- Obstetrics Levels II & III
- Ophthalmology surgery
- Orthopedic surgery
- Organ transplant
- Vascular surgery
- Trauma critical care
- Neonatal and pediatric surgery

There are 15 private and specialty hospitals and facilities frequently used by MSU to provide unmet needs and to handle cases that are beyond the capacity of the current IHS health system. These facilities include:

- Las Cruces Medical Center, Las Cruces, NM
- Presbyterian Hospital, Albuquerque, NM
- St. Joseph Medical Center, Albuquerque, NM
- Heart Institute of New Mexico, Albuquerque, NM
- Memorial Medical Center, Ruidoso, NM
- Eastern New Mexico Medical Center, Roswell, NM
- Covenant Hospital, Lubbock, TX
- Texas Tech University Hospital, Lubbock, TX
- University of New Mexico Hospital, Albuquerque, NM
- University of New Mexico Mental Health Center, Albuquerque, NM
- Gerald Champion Medical Center, Alamogordo, NM
- Lincoln County Medical Center, Ruidoso, NM
- Covenant Medical Center, Lubbock, TX
- Thomason General, El Paso, TX

A list obtained by search of the Yellow Pages shows that additional facilities are available within 50 miles of Mescalero. This list is included in Appendix G.

Ambulatory Medical Services

In 2004, the MIH registered 33,831 outpatient visits, representing 5% of the entire Albuquerque Area ambulatory visits. Statistics indicate that the MSU realized a 29% increase in the number of outpatient visits from 1999 to 2004.

Mescalero Service Unit Total Outpatient Visits
1999 - 2004

1999	2000	2001	2002	2003	2004	% Change 1999-2004	2004 % of MSU Total
26,307	29,830	30,318	34,068	34,589	33,831	29%	22%

The following chart show a snapshot of the top 50 reasons for outpatient visits to MIH in 2004. These data are presented as a summary of the type of workload burden on the Service Unit and MIH's operation as an outpatient clinic rather than an in-patient hospital. Appendix H shows outpatient visit volume by diagnostic category and age for MIH from 1999 to 2004.

Mescalero Indian Hospital Top 50 Diagnoses 1999-2004

	MESCALERO			2004	1999-2004
2004 RANK	**ICD DIAGNOSIS NAME**	**1999**	**2004**	**% of Total**	**% Change**
1	Issue Repeat Prescript	3,157	6,522	19%	107%
2	Dental Examination	1,834	2,440	7%	33%
3	Acute Uri Nos	1,344	1,119	3%	-17%
4	Diab Uncomp Typ Ii/Niddm	672	1,031	3%	53%
5	Otitis Media Nos	641	920	3%	44%
6	Routin Child Health Exam	650	759	2%	17%
7	Vaccine And Inocula Influenza		658	2%	
8	Allergic Rhinitis Nos	148	498	1%	236%
9	Supervis Oth Normal Preg	510	495	1%	-3%
10	Myopia	242	436	1%	80%
11	Health Exam-Group Survey	34	410	1%	1106%
12	Acute Pharyngitis	452	393	1%	-13%
13	Noninf Gastroenterit Nec	297	382	1%	29%
14	Chronic Sinusitis Nos	191	381	1%	99%
15	Depressive Disorder Nec	179	352	1%	97%
16	Bronchitis Nos	210	349	1%	66%
17	Gynecologic Examination	203	296	1%	46%
18	Contraceptive Mangmt Nos	58	289	1%	398%
19	Urin Tract Infection Nos	210	264	1%	26%
20	Attn Deficit W Hyperact	177	255	1%	44%
21	Hypertension Nos	211	250	1%	18%
22	Panic Disorder	146	240	1%	64%
23	Adjustment Reaction Nos	54	230	1%	326%
24	Prophylactic Measure Nos	369	220	1%	-40%
25	Supervis Normal 1st Preg	90	214	1%	138%
26	Backache Nos	104	206	1%	98%
27	Dietary Surveil/Counsel	16	203	1%	1169%
28	Dermatitis Nos	133	199	1%	50%
29	Strep Sore Throat	70	198	1%	183%
30	Abdominal Pain, Uns Site	220	197	1%	-10%
31	Astigmatism Nos	124	193	1%	56%
32	Recurr Depr Psychos-Mod	49	192	1%	292%
33	Contracept Pill Surveill	109	184	1%	69%
34	Hypermetropia	67	181	1%	170%
35	Alcoh Dep Nec/Nos-Unspec	96	173	1%	80%
36	Asthma Unspecified	126	165	0%	31%
37	Contracept Surveill Nec	180	163	0%	-9%
38	Lumbago	142	151	0%	6%
39	Pain In Limb	28	146	0%	421%
40	Infec Otitis Externa Nos	41	136	0%	232%
41	Eye & Vision Examination	21	131	0%	524%
42	Unspec Viral Infections	214	128	0%	-40%
43	Rheumatoid Arthritis	48	125	0%	160%
44	Esophageal Reflux	61	120	0%	97%
45	Headache	134	120	0%	-10%
46	Diab Uncontrol, Type Ii	22	119	0%	441%
47	Acute Sinusitis Nos	71	118	0%	66%
48	Screening-Pulmonary Tb	133	117	0%	-12%
49	Cellulitis Of Leg	97	110	0%	13%
50	Family Circumstances Nec	15	108	0%	620%
	All Other	11,907	10,545	31%	-11%
		26,307	**33,831**	**100%**	**29%**

Health Service Priorities

Service Unit Board Ranked Clinical Priorities

using the questionnaire provided in Appendix I the MSU Health Board was asked to consider priorities of care,. After presentation of statistical health and patient visit data, a one-day meeting was held with the Health Board to determine the level of care that they wanted to see within the MSU. The standard provider list that is used within the Health Systems Planning process to create the RRM was used as a basis for determining what type of provider care was desired. A more detailed version of the health board's priorities appears in Appendix J.

Desired Services by MSU Health Board

Mescalero Health Service
Desired Services by MSU Health Board

Physician Care	AMBULATORY CARE	ELDER CARE	INPATIENT CARE
Family Practice	Nutrition	Skilled Nursing (Nursing Home)	Labor & Delivery
Internal Medicine	Optometry	Assisted Living (Nursing Home)	Labor & Delivery – low risk
Pediatric	Podiatry	Hospice (Nursing Home)	Medical Inpatient
Gynecology	Dialysis	Home Health Care	Pediatric
Dermatology	Audiology	**WOMEN'S CARE**	Sub Acute / Transitional Care
Orthopedics	Chiropractic	Ultrasound – OB	Adolescent Substance Abuse
Gerontology	Acupuncture	Pap smears	Adult Substance Abuse
Radiologists	**WELL BABY/WELL CHILD**	STD treatment / counseling	**OTHER SERVICES**
Nephrology (Clinic)	Post partum baby checks	Birth Control counseling	Case Management
Rheumatology (Clinic)	Vaccinations	**MEN'S CLINICS**	Environmental Health
Traditional Healing	**ANCILLARY SERVICES**	Prostate screening	Transportation
Dental	Staffed Pharmacy	STD treatment / counseling	Public Health Nursing
Labor & Delivery – birthing center	Lab Specimen Collection	Birth Control counseling	Public Health Nutrition
EMERGENCY / ICU	Clinical Lab	**BEHAVIORAL HEALTH**	Health Education
Emergency	X-Rays	Psychiatry	School Education - dental
Ground Ambulance	Ultrasound Level I	Mental Health	School Education - prevention
PREVENTIVE MEDICINE	Physical Therapy	Social Services	After Hour & Weekend clinics
Diabetes	Occupational Therapy	Alcohol & Substance Abuse - After Care, Rehab, Follow-up (Rehab Unit)	Daibetes Clinics
Hypertension	Speech Therapy	Substance Abuse Transitional Care (Rehab Unit)	Epidemiology Services
	Respiratory Therapy	Medical Detox	Coding and Medical Records
			Benefits Coordinator
			Adult and Child Protection, Intervention

The Health Board was then asked to rank the types of services and care that they wanted to see provided. This list of priorities is included below. (Note: Every "1st priority" vote equals 10 points, and every "2nd priority" vote equals 5 points.)

Prioritization of Desired Services

SERVICE	1st Priority	2nd Priority	Total	
Ground Ambulance	60	5	65	DEFINITE
Transportation	60	5	65	
Gynecology Services	60		60	
Home Health	60		60	
Dental and Pediatric Dental	50	5	55	
Hypertension	30	20	50	PROBABLY
Diabetes	40	10	50	
Labor and Delivery	50		50	
Radiology	50		50	
Nutrition/ Dietician	30	15	45	
Traditional Healing	40	5	45	
Vaccinations	40	5	45	
Optometry, Ophthalmology (Teleoptometry)	40		40	
Dermatology		40	40	
Pediatrics	30	5	35	
Medical Detox	10	20	30	MARGINAL
Dialysis	20	10	30	
Hospice	20	10	30	
Rheumatology	20	10	30	
Chiropractic	30		30	
Assisted Living		30	30	
Child psychiatrist - contract	10	15	25	
Nephrology	10	15	25	
Podiatry	20	5	25	
Psychiatry	20	5	25	
Acupuncture		25	25	
Orthopedics		25	25	
Skilled Nursing	10	10	20	
Allergies	20		20	
Family Practice	20		20	
Audiology		20	20	
Internal Medicine		20	20	
Post-Partum		10	10	DROP
Gerontology		5	5	

This is an ambitious list for a facility that has been struggling financially and having problems maintaining appropriate staffing level and mix. In addition, given the focus and importance placed on diabetes, an endocrinologist would be a valuable addition to the complement of medical staff.

Tribal leaders and health board participants defined quality of care not only as attention to the technical aspect of medicine—measurement indicators such as tests, diagnostics, practice, and pharmaceuticals—but also attention to the individual and access to care. Each factor was considered equally. Access to community-level care by well-trained medical providers was of critical importance to tribal leaders.

Projected Service Need - Quantitative

Projected service need—which will ultimately drive the need for space to accommodate medical providers to fill the service need—is based on historical patterns of use at MIH. The following chart provides projections to the year 2015 on categorized groupings of patient visits. It is common practice within the health industry to categorize patient visits to better plan for provider specialties and workloads. All data are projected to the year 2015, based on historical use. The low estimate is based on actual annual growth 1999 to 2004, the high estimate is based on average annual percentage increase 1999 to 2004.

The following pages include diagnostic, patient visit, and provider workload data that are projected to the year 2015 and are being used to help determine service and facility needs.

The chart, “Staffing Needs Summary Projections to 2015” is included as Appendix K, with “Provider Workload and Facility Need Projected to 2015” as Appendix L. Both charts are incomplete for this draft until we receive additional information from MSU clinic staff and administration. Once completed, however, they will provide an estimate of the number of examination rooms needed to fulfill projected service needs in the year 2015, based on historical patient visits.

MSU Patient Visit History Grouped By Diagnostic Category Projected To 2015

	# of Patient Visits		Average Annual % Change 1999-2004	LOW*		HIGH**	
Group	**1999**	**2004**	**99-04**	**2010**	**2015**	**2010**	**2015**
Certain Conditions Originating in the Perinatal Period	47	41	-2.6%	34	35	28	31
Complications of Pregnancy, Childbirth, and the Puerperium	86	81	-1.2%	75	76	70	71
Congenital Anomalies	40	31	-4.5%	20	24	11	19
Diseases of the Blood and Blood-Forming Organs	138	135	-0.4%	131	132	128	129
Diseases of the Circulatory System	353	505	8.6%	687	829	839	1,253
Diseases of the Digestive System	880	1,096	4.9%	1,355	1,461	1,571	1,857
Diseases of the Genitourinary System	691	724	1.0%	764	766	797	804
Diseases of the Musculoskeletal and Connective Tissue	1,173	1,663	8.4%	2,251	2,691	2,741	4,020
Diseases of the Nervous System and Sense Organs	1,840	2,555	7.8%	3,413	4,003	4,128	5,820
Diseases of the Respiratory System	3,242	3,416	1.1%	3,625	3,642	3,799	3,842
Diseases of the Skin and Subcutaneous Tissue	941	966	0.5%	996	997	1,021	1,024
Endocrine, nutritional, metabolic diseases, and immunity disorders	1,016	1,664	12.8%	2,442	3,420	3,090	6,233
Infectious and Parasitic Disease	1,080	1,299	4.1%	1,562	1,649	1,781	2,012
Injury and Poisoning	1,993	1,628	-3.7%	1,190	1,301	825	1,080
Mental Disorders	1,413	2,130	10.1%	2,990	3,804	3,707	6,168
Neoplasms	64	112	15.0%	170	259	218	521
Other / Supplemental *	9,879	14,682	9.7%	20,446	25,620	25,249	40,746
Symptoms, Signs, and Ill-defined conditions	1,431	1,103	-4.6%	709	832	381	658
TOTALS	**26,307**	**33,831**		**42,860**	**51,542**	**50,384**	**76,287**

Source: IHSPES Data

** Other / Supplemental includes the following categories ranked in frequency of patient visits:*

1. Issuance of prescriptions
2. Dental examination
3. Laboratory
4. Eye Exam / glasses / contacts
5. Vaccination
6. Pregnancy
7. Routine infant or child health check
8. Contraception
9. Other encounter for administrative purpose
10. Gynecological Exam
11. Health education / instruction
12. Tuberculosis
13. Other medical exam
14. Physical therapy
15. Dietary consultation
16. Radiological exam

** Low is projected based on absolute annual growth 1999-2004*
***High is projected based on average annual % increase 1999-2004*

User Population

The number of Active User patients at MSU rose by 9% from 1997 to 2004. Non-Mescalero tribal members use the MIH as an ambulatory clinic because many of them are employed by a Mescalero tribal business entity such as the casino. See Migration Data, Appendix M for information regarding tribe of membership for all Active Users in MSU.

Based on historical use patterns outlined in the previous page, the MSU health care delivery system will likely see a 10-15% rise in Active User population by the year 2015. It should be noted however, that there remains a gap of approximately 560 between enrolled Mescalero Indians and the Active User Population.

Mescalero Service Unit Active User Populations

Tribe	1997 User Population (1)	2004 User Population (2)
Other*	772	840
Mescalero	3280	3607
MSU Total	**4052**	**4447**

(1) Active User = Indians using IHS system within the period September 30, 1994 – September 30, 1997

(2) Active User = Indians using IHS system within the period October 1, 2001 – September 30, 2004

* Other = Other Indian Users / "Urban" Indians

Urban Indians

The term "Urban Indians" refers to any American Indian or Alaska Native who is living outside of his / her reservation boundary and who is enrolled with IHS to receive medical services at a facility other than the home Service Unit. IHS medical facilities—or tribal facilities that receive medical service funding through IHS—may not refuse ambulatory or in-hospital medical service to any American Indian or Alaska Native who seeks care, regardless of whether he or she is a member of that particular Service Unit. Use of Contract Health Service dollars is restricted, however, to enrolled members of the Service Unit or any Indian who lives on the Mescalero Apache Reservation.

Approximately 19% of the MSU Active User Population is composed of "Urban Indians". Unless these patients have private insurance, or are qualified for Medicare or Medicaid, the Service Unit bears the financial responsibility for their ambulatory medical and dental care.

IHS does not currently provide direct funding to any of the Albuquerque Area Service Units to pay for the medical care of Urban Indians, although a small percentage of funds received for health services is budgeted for this need. As a

result, Service Units and individual medical facilities bear the burden of care for these individuals. Providing care to this population is at the expense of providing or expanding services to Mescalero Apache Nation members. Enrolled members of the Mescalero Nation do not appear to travel to receive care at other IHS facilities. Only 71Active Users from Mescalero Apache Nation received care at the Albuquerque Area Clinic in 2004, and another 44 registered for care at Santa Fe Indian Hospital.

Across the country, the issue of providing health care to Urban Indians has pointed out problems with tying funding to facilities and specific user populations.

Appendix M contains “migration pattern” information regarding the home communities and number of patients receiving care at the MSU facility.

IHS vs. National Averages

The following chart outlines MSU patient use rates by diagnostic categories as compared to national averages. The highlighted categories indicate areas in which the MSU population is experiencing excessively higher (or lower) rates of patient visits compared to the national average. This can mean that the MSU population has better access to medical care or is using the medical care more frequently than the national population at large for these conditions. In fact nationwide, 45 million individuals between the ages of 18-64 are uninsured and have no access to medical care on a regular basis.

From these figures it is clear that the MSU population accesses IHS medical services for almost every category at a much greater level than the population-at-large. Services for Mental Disorders and Infectious / Parasitic Diseases show extremely high rate of use while diseases of the Digestive System are considerably higher than the national average.

Availability of health services has a substantial impact on health measures. It has been demonstrated by interviews, health board reviews, statistics, and site visits that the MSU services involving community clinics, outreach, education, and preventive health services are not adequate to meet needs, primarily due to budget restrictions.

Mescalero Service Unit Outpatient Visit Utilization vs. National Use Rates

ICD-9 Diagnostic Category (Patient Visits per 1,000 population)	(A) Service Unit Use Rate	(B) National Use Rate	# Difference	% Difference
Diseases of the Circulatory System	113.6	299.1	185.5	163%
Diseases of the Digestive System	246.5	112.6	-133.9	-54%
Diseases of the Genitourinary System	162.8	159.9	-2.9	-2%
Diseases of the Musculoskeletal and Connective Tissue	374.0	252.4	-121.6	-33%
Diseases of the Nervous System and Sense Organs	574.5	295.4	-279.1	-49%
Diseases of the Respiratory System	768.2	421.3	-346.9	-45%
Diseases of the Skin and Subcutaneous Tissue	217.2	158.7	-58.5	-27%
Endocrine, Nutritional, Metabolic Diseases, And Immunity Disorders	374.2	200.4	-173.8	-46%
Infectious and Parasitic Disease	292.1	95.3	-196.8	-67%
Injury and Poisoning	366.1	203.1	-163	-45%
Mental Disorders	479.0	156.2	-322.8	-67%
Neoplasms	25.2	97.1	71.9	285%
Other / Supplemental *	3,297.1	562.8	-2734.3	-83%
Symptoms, Signs, and Ill-defined Conditions	247.4	214.1	185.5	163%
All Other	113.6	299.1	-133.9	-54%

Data Source Notes: (A) Service Unit Use Rates are based on 2002 visit data and Census data (2002 population projected by applying Albuquerque area growth factor 2000-2002 to MSU); (B) National Use Rates: 2002 National Hospital Ambulatory Medical Care Survey & National Ambulatory Medical Care Survey & National Hospital Ambulatory Medical Care Survey-ED data from the National Center for Health Statistics at the CDC.

**Other / Supplemental refers to:*
Issuance of prescriptions
Dental examination
Other medical exam
Physical therapy
Eye examination / glasses / contacts
Radiological exam
Pregnancy
Routine infant or child health check
Other encounter for administrative purpose
Tuberculosis
Gynecological Exam
Laboratory
Contraception
Dietary consultation
Vaccination
Health education / instruction
Health exams of defined subpopulations

Budget Issues

Despite limited – and decreasing funding relative to patient growth, MSU has demonstrated the ability to provide basic health care to the 4,447 total Active Users within its boundaries. This has been achieved in spite of lower per capita expenditures for health care, estimated by the IHS to be less than 60% of national levels, and lower availability of health care services (25% annual availability of dental services versus 60% for U.S. population overall). The following chart outlines the MSU budget in light of increased patient visits.

Mescalero Service Unit Budget

MSU BUDGET

	FY 1997	FY 2003	FY 2004	Number Change 1997 - 2004	% Change 1997 - 2004
REVENUES					
Total Federal Appropriation (1)	$3,976,004	$4,889,921	$4,904,672	$928,668	23%
3rd Party Collections	$1,147,018	$1,877,441	$1,811,383	$664,365	58%
Subtotal Revenues	**$5,123,022**	**$6,767,362**	**$17,037,183**	**$11,914,161**	**233%**
EXPENSES					
Hospitalizations (2)	$503,176	$1,130,773	$757,784	$254,608	51%
Dental (2)	$61,896	$21,941	$10,766	($51,130)	-83%
Total CHS Expenditures (2)	**$565,072**	**$1,152,714**	**$768,550**	**$203,478**	**36%**
POPULATION SERVED					
ACTIVE USER POPULATION	4,052	4,220	4,447	395	10%
OUTPATIENT VISITS (3)	25,535	34,629	33,831	8,296	32%
INPATIENT Admissions	317	191	208	-109	-34%

(1) IHS Recurring Budget without CHS
(2) IHS Albuquerque Area Operational Summaries directly from RPMS
(3) All data from IHPES/ORYX with exception of 1997 Outpatient Visits

Complicating these factors are the limited number of providers – almost 50% less per capita than the U.S. population overall.

The annual IHS budget has been increasing only approximately 3% per year for facilities and services –much of which must be used for federally mandated “Cost of Living Adjustments” for staff salaries. The impact of this minimal increase on the IHS’ ability to provide quality health care services cannot be understated. It has also resulted in underfunding of facilities, equipment, and other capital investment necessary to provide adequate health care services.

Projected Service Need - Qualitative

Medicare and Medicaid Changes

MSU (and indeed all of the Albuquerque Area IHS) has exponentially increased its reliance on Medicaid, which is a revenue stream that is increasingly at risk. With the federal budget deficit growing, the implications for health care are huge. Approximately one-quarter of the federal budget is made up of Medicare and Medicaid. As the number of Medicare enrollees increases with an aging population, it is estimated that by 2010, 70 million Americans will have two or more chronic conditions. In addition, the number of working Americans paying taxes to support the Medicare Hospital Insurance Trust Fund will begin decreasing dramatically by the year 2015. Current projections by the Social Security and Medicare Boards of Trustees expect the Trust Fund to go broke in the year 2019.

At the same time, Medicare and Medicaid funding requirements will become increasingly difficult, and IHS will be progressively more challenged to provide the infrastructure required to meet these new requirements. It is expected that some form of “pay for performance” will be instituted so that payment will be based on performance indicators rather than outcomes.

With more than 25% of its revenue dependent on Medicare and Medicaid funding, the MSU will need to make difficult changes to accommodate its future existence.

Indian Self Determination Act (P.L. 93-638)

As tribal leaders search for better health care services for their members, interest has grown in exercising their rights under the Indian Self Determination Act (ISDA) to assume responsibility for providing health care services. The Mescalero Apache Tribe has exercised its options to contract services under the Health Education program amounting to $46,496 in 2004.

NPIRS and GPRA

National Patient Information Reporting System (NPIRS) and Government Performance Reporting Act (GPRA) are two performance indicators used by the Federal Government to measure health program efficacy.

NPIRS is a method of measuring data for what services are being performed, how the services are being performed, and how well the services are being performed. It provides a measurement tool for health care delivery as well as evaluation standards for funding.

GPRA addresses clinical performance indicators and measures the number of patients with specific diseases. It establishes protocols for each disease. GPRA defines national standards of care that must be met in order to continue receiving funding.

In providing health and diagnostic data to tribal leaders, the question of whether patients with diseases such as Diabetes Mellitus Type 2 or hypertension were receiving adequate care was often discussed. The IHS' own Standard of Care for patients with Diabetes Mellitus Type 2 is described in nine broad categories:

- Baseline studies, which should include recording patient height and date of diabetes diagnosis, obtaining a baseline Electrocardiogram (ECG) and then repeating it every one to five years as clinically indicated, documenting pulmonary function (PPD) to assess the presence of latent or active tuberculosis, and assessing and recording whether the patient also is diagnosed with depression;
- Clinic visits, which should include recording weight, blood glucose, and blood pressure and also conducting an examination of feet and nails;
- Annual tests to include complete urinary analysis, microalbuminuria, lipid profile, eye exam, dental exam, complete foot exam, and screening for neuropathy.
- Immunization and skin tests, including flu vaccine, vaccination against pneumovax, Td, hepatitis B, and PPD;
- Special aspects of diabetes care, which include antiplatelet therapy and avoidance of tobacco use;
- Self-care education, which includes nutrition, diabetes, exercise education as well as self-blood glucose monitoring;
- Routine health maintenance, including physical exam, pap smear/pelvic exam, breast exam, mammogram, rectal exam and prostate (PSA) and colorectal cancer screening;
- Pregnancy and diabetes, which includes pre-pregnancy counseling for optimizing metabolic control prior to conception and well as counseling regarding lifestyle modifications that will reduce or delay the development of type 2 diabetes; and
- Tuberculosis, which includes protocols for testing for latent or active tuberculosis infection and also describes treatment protocols.

Educating Consumers

There is an absence of brochures and pamphlets that describe services provided, hours of operation, availability of specialty clinics, and procedures for making appointments. Not having the information increases the number of walk-ins, creating a burden for the providers as well as crowding in the clinics. Reminder calls could assist in decreasing the number of "no-shows," which result inefficient use of providers.

CONTRACT HEALTH SUMMARY

Contract Health Service Expenditures

In most Service Units, Contract Health Service Expenditures are growing annually. MSU expenditures however, appear to be flat or decreasing. This may imply that more services are being offered through the MIH ambulatory and inpatient medical care. It may also imply however, that patients are receiving fewer referrals for specialty care. Further investigation would be needed to identify which scenario is more likely to be the case.

Contract Health Service Expenditures

MSU	FY 97	FY 03	FY 2004	# Change 97 - 04	% Change 97 - 04	# Change 03 - 04	% Change 03 - 04
Total CHS expenditures	$1,713,483	$2,646,405	$2,152,129	$438,646	26%	($494,276)	-23%
Hospitalization	*$503,176*	*$1,130,773*	*$757,784*	*$254,608*	*51%*	($372,989)	-49%
Dental	*$61,896*	*$21,941*	*$10,766*	*($51,130)*	*-83%*	($11,175)	-104%
Non-hospital service	*$1,148,411*	*$1,493,692*	*$1,383,578*	*$235,167*	*20%*	($110,114)	-8%

At MSU, CHS expenditures are used to pay for services that may or may not be available directly from IHS and that are purchased under contract from community hospitals and specialty practitioners. CHS services are provided almost exclusively based on a 'priority' system, including Priorities One through Four listed on the following pages.

Priority One

In June 2004 budget restrictions nationwide forced the IHS to limit access to CHS health care providers to Priority One—services which are required to prevent immediate death or serious impairments. These are:

- Obstetric and Pediatric Emergencies
- Medical emergencies
- Eye emergencies
- Psychiatric emergencies – up to 14 days
- Dental emergencies
- Renal replacement therapy, including transplant
- Emergency transportation
- Surgical emergencies, including orthopedic and gynecological
- Extra depth shoes with custom-molded inserts that meet specific criteria
- Ears, nose, throat (ENT) surgery required when immediate threat to development of speech language
- Gynecological tubal ligation

Other services, many of which are preventive or diagnostic in nature, are currently restricted and are not covered for IHS Contract Health Services. These include services designated as Priorities Two, Three, and Four.

Priority Two

Services are required for potentially life-threatening /severe handicapping conditions and to maintain JCAHO accreditation. In the past, most services listed under Priority 2 have been available at IHS direct care facilities; however, loss of personnel who cannot be replaced or loss of services due to budget restrictions have increased the amount of services sent for CHS expenditures, thereby limiting the services covered under IHS criteria. Priority 2 services include:

- Laboratory/radiology/nuclear medicine not available onsite
- Specialty consultation for acute care diagnosis, cancer, high risk OB, etc.
- Backfill for vacant positions in lab, x-ray, pharmacy, as well as physicians, nurses.
- Psychiatric ambulatory and inpatient services
- Non-emergency elective surgery
- Podiatry services – high risk medical
- Prosthetics and appliances

Priority Three

Services contribute to better patient functioning but are not necessarily to prevent death or serious impairment. These include:

- Patient rehabilitation
- Specialty consultation when less than Priority 2
- Hearing aids
- Podiatry / orthopedics – less than Priority 2
- Allergy services
- Preventive medicine / health promotion activities
- Orthodontic services

Priority Four

Services included:

- Long-term residential psychiatric care
- Rehabilitation surgery
- Nonemergency transportation
- Elective surgery–cosmetic

Every Service Unit has the ability to apply third party reimbursements to pay for services, including those listed under Priorities 1, 2, 3 and 4. A Medical Priorities Committee within each Service Unit determines spending plans and authorizes payment for CHS referrals.

The result of these restrictions on expenditures for CHS providers can be devastating. For example, podiatry services are not provided full time, although diabetes is on the rise. If uncontrolled diabetes and poor foot care results in lower limb amputation, the patient may not receive a prosthetic limb if CHS dollars are overspent for the fiscal year. If dental services are restricted and a patient has teeth removed, IHS does not pay for orthodontics (a dental bridge or implant) to help with chewing of food and digestion, which can lead to other digestive complications down the line.

If facility usage trends and health indicators continue to change, and the Mescalero Service Unit continues to outsource medical services, these numbers will increase exponentially.

The top ten reasons for hospitalizations at facilities other than the Mescalero Indian Hospital are provided in Appendix O. These services were provided through Contract Health Services and represent individual purchase orders – patients who were admitted either through the emergency room or referred by

IHS. In some instances, the services for in-hospital care cannot reasonably be expected to be provided by the MIH due to restrictions on its equipment and staffing. Most small hospitals across America are facing similar restrictions and rely on larger regional medical facilities to make the capital investments to treat complicated cases.

Moreover, it was discussed by patients and staff that the Service Unit often runs out of CHS dollars before the end of any given fiscal year. The exhaustion of CHS funds is not confined to MSU, however, it is a commonly reported issue throughout IHS and across the country. If referrals are made IHS may not be able to pay for the services rendered until the next fiscal year's budget is in operation.

In some cases across the country (but not reported yet in MSU) contract health providers have refused to see patients because they are due payment. In other cases, MSU patients, health board members, and tribal administrations report that individuals are held responsible for payment of medical bills that IHS' CHS has assumed obligation to pay. When payments have not been received by providers in timely manner, individuals are reported to credit bureaus for negligence and their credit rating is negatively affected or sometimes ruined, because IHS has not paid the bill.

Facilities Master Plan

IHS Supportable Space – Health Systems Planning Criteria and Population Mapping

To provide a consistent methodology to determine health care service and facility needs to Native American communities IHS engages a variety of computerized formulas and software that contain population and medical workload data. Unfortunately these programs do not adequately address medical needs for communities of less than about 1,320 Active Users, with approximately 4,400 primary care provider visits annually. Although Mescalero Apache Reservation does meet and exceed criteria for ambulatory health centers, the population does not meet the required threshold for an inpatient facility.

The Health Systems Planning (HSP) software used by IHS provides population, workload projections, and space requirements for new or remodeled health care facilities. This information is of special interest to planners, and some of it is needed to use the Resource Requirements Methodology (RRM) which determines staffing needs for facilities.

The Health Systems Planning software for Mescalero Indian Hospital was run with the 2002 Active User population of the Mescalero Apache Nation in addition to Urban Indians. Because the combined Active User Population of 4,447 falls under the required “threshold” planning formula of 5,000 AND the Average Daily Count falls far below the 6 bed template range for a rural hospital, the HSP was modified for in-patient planning purposes.

HSP uses formulas based on Total Primary Care Provider Visits (PCPVs). PCPVs to include physician visits for diagnosis typically seen by Family Practice, Internal Medicine, Pediatric, Obstetric/Gynecology, Tribal Physicians and Mid-Level Practitioners that support these specialties. The consultants used Outpatient visits to more accurately reflect provider workload based on need out of concern that PCPV use would not reflect true need when contract health providers and specialists are commonly used.

To arrive at a workload projection that reflects both the trends of managed care and the demographic character of the communities served by IHS facilities, the following methodology was applied. The average provider minutes spent per patient seen across the U.S. for each of the four dominant “primary care specialties”:

- Family Practice ..... 19 minutes per patient visit
- Internal Medicine..... 26 minutes per patient visit
- Pediatrics ..... 19 minutes per patient visit
- OB/Gyn ..... 22 minutes per patient visit

These provider time profiles were then weighted according to a statistical average demographic distribution of sample IHS communities to arrive at a "weighted average provider time" per IHS primary care patient visit. The average demographic distributions applied are:

- Family Practice 20%
- Internal Medicine.....22%
- Pediatrics 28%
- OB/Gyn 30%

The resulting weighted average provider time per PCPV is 21.5 minutes. Primary Care Providers perform 1,720 hours per year of direct patient care. A Primary Care Provider sees patients at 90% efficiency during direct patient care times. Primary Care Providers can accommodate 4,300 PCPVs per year.

Exam Room Quantity

For the HSP each primary care provider is allotted 2 examination rooms for his/her dedicated use, when staffed according to each template's provider capacity. If exam rooms are not dedicated to a specific individual provider, and are instead scheduled "on demand" (meaning next available patient &/or provider) the template PCPV capacity is increased by one-third.

Resource Requirements Methodology

The IHS' Resources Requirements Methodology is a system designed to project the staffing needs for a specific facility or primary service area. It is available in a computer spread sheet program to assist with the preparation of staffing estimates. To use the RRM, essential workload information is gathered and entered into the worksheets where it serves as the driving variables for each discipline. The goal of RRM is to help ensure that IHS provides appropriate, reasonable, and consistent staffing information to Congress and Tribes.

The main purpose of the RRM model is to project staffing (in this case to the year 2015) that will be used in the development of Program Justification Documents (PJD), Project Summary Documents (PSD) or tribal requests for technical assistance in the submittal of U.S. Department of Housing and Urban Development Indian Community Block Grant Proposals. Experts in the various disciplines compared staffing ratios with industrial standards in developing the formulas for the program, as well as benchmark information from existing IHS facilities.

The RRM is reviewed periodically and updates are made as they are needed. The current approved version of the RRM is RRM2004, using Active User Population of 2002. Essential elements of the Preliminary RRM prepared for Mescalero Indian Hospital are provided in Appendix P. Appendix Q contains the Program Justification Documentation and the Workload Summary for the MIH.

The justification for the inclusion of Acute Care Inpatient Beds in a new health care facility is dependent upon the standards and policies set forth in paragraph 4-2.2 of Chapter 2 of the Indian Health Manual.

The number of bed days projected as necessary for a future facility will depend on the service areas age and sex demographics and the following age and sex utilization rates (annual beddays/user) by service:

Medical	Age Group	Male	Female
	15-19	.0524	.0523
	20-24	.0524	.0523
	25-34	.0860	.0626
	35-44	.1318	.0692
	45-54	.2179	.1739
	55-64	.2179	.1739
	65+	.4890	.3936
	Total	.0935	.0795

Total (both sexes): .086

With an average age and sex demographic breakdown, the admission rate is envisioned to be .025 per user. The Average Length of Stay will be 3.68 days. MSU does not meet the HSP's minimum requirements for an Acute Care Hospital.

Facilities Size, Age and Condition

The Facility Sheet for the Mescalero Indian Hospital found on page 31 includes information from the FEDS Deficiencies list. All of the MIH buildings are at least 37 years old. The standard life expectancy of medical facilities is approximately 40 years, meaning that in the private sector these buildings would be almost fully amortized and ready for major renovation or replacement.

Mescalero Indian Hospital Facility Review

- Mescalero Indian Hospital Facility 2004 User Population : Outpatient / Ambulatory User Population = 4467
- Existing Space: Total Area = 52,392 square feet. Inpatient and Outpatient: 25,890 square feet plus administration, housing, facility support, dietary.
- Total Outpatient / Ambulatory Care Space Required for 2015 User Population Projections: Total 73,530 square feet

The Mescalero Service Unit maintains a small campus of buildings that includes

- 25,890 Sq. foot facility including hospital / ambulatory / dental / pharmacy / laboratory / housekeeping
- 1,800 sq. foot inpatient unit
- Administrative buildings
- 11 Living Quarters
- Field offices containing:
  - -Audiology
  - -Optometry
  - -Behavioral / Mental Health
- Warehouse
- 11 Storage sheds
- 4-car garage
- 47 parking + 6 handicapped parking

Originally built in 1968 the two-story Mescalero Indian Hospital has had a number of minor renovations to accommodate a significant increase in outpatient numbers. Among the major changes is the transformation of a section of the second floor inpatient ward into a limited care inpatient unit and ambulatory care examination rooms.

The hospital was designed to accommodate a total of 13 inpatient beds (7 medical/surgical, 4 pediatric, 2 obstetrics beds), currently staffed for 11 inpatient beds. The nursery has been closed and converted to storage; two pediatric beds remain in one room; and two of the original inpatient rooms are being used for a variety of ambulatory exam and storage use.

The inpatient ward is separated from the ambulatory clinic by sets of double doors, and maintains its own nursing station. An Isolation room is provided for infections patients but it does not employ reverse air flow to help prevent the spread of infectious disease.

As the inpatient workload has reduced, outpatient activity has expanded considerably. This has resulted in the conversion of a variety of spaces into outpatient examination/treatment rooms, creating an outpatient clinic operation that is physically fragmented and operationally inefficient and making it difficult to separate inpatient and outpatient traffic flows within the hospital. Outpatient services would be more effectively provided if they were concentrated in one area of the Hospital, separated from the inpatient beds. As a result, many of these spaces are inappropriately sized for the functions that they currently house.

Depending on the day of the week and the type of specialty clinic in process patients may be directed to one of six exam rooms on the first floor, or one of six exam rooms on the second floor. Also on the second floor is a triage room, the 'emergency' entrance, an ultrasound room that doubles as storage, and the 'procedures' room.

The second floor contains the cafeteria with food storage and dietician's office, a tiny kitchen, four over-crowded storage rooms, clean and soiled utility rooms, and janitor closet. A small conference room which doubles as a staff lounge is located adjacent to the computer room/ information management and small break room crowded with supplies and machinery as well as a public nursing office. Finally, the second floor contains the nursing director's office, a small medical supply office and equipment storage.

In addition to six examination rooms, the first floor of the Mescalero Hospital contains the business office, data entry, medical staff offices, medical records, the laboratory, the pharmacy, and xray department.

There are now three dental operatories on the first floor with the dental office, a small dental reception room, and a shared dental dark room / storage space.

In order to accommodate growth in the pharmacy's workload, a large area that was formerly part of the pharmacy operations has been converted into staff office space. This has compromised the availability of storage space.

Several administrative functions such as billing, contract health, and information technology have grown significantly during the past 37 years and have had to improvise to find adequate space. For example, the data entry occupies an area that was originally constructed as a maintenance shop, and information technology uses a former inpatient doctor's office on the 2nd floor as an office area.

The radiology area and the outpatient exam rooms on the first floor are located next to each other, which allows for easy patient movement.

Audiology services, provided 1 day / month, and the Optometry office share a building site located approximately 500 yards, across two parking lots and down a pair of steps from the Hospital. Behavioral Health Department is located in a separate building also down a pair of steps and across two parking lots from the Hospital. Its relative seclusion from the Hospital provides a level of privacy for patients; the office space appears to be well utilized.

Preliminary Mescalero Indian Hospital Space Summary

Draft SPACE SUMMARY PLAN (Mescalero Hospital Year 2015)

Existing net and gross areas for the proposed facility are summarized below, without inpatient care

MESCALERO IH	Net Square Meters	Conversion Factor	Gross Sq Meters CURRENT	Gross Sq Meters 2015
ADDITIONAL SERVICES				
X01			1.35	8.1
X02			1.35	27
X03			1.35	493.29
ADMINISTRATION				
Administration	213.85	1.4	299.39	270.2
Business Office	97.13	1.4	135.98	155.4
Health Info Manage				241.25
Information Manage	76.25	1.2	91.5	75.6
AMBULATORY				
Dental	54.58	N/A	54.58	653
Emerg/Urgent/Security	76.63	N/A	76.63	82
Eye Care				163
Primary Care	105.04	N/A	105.04	487
Primary Care				487
ANCILLARY				
Diagnostic Imaging	40.65	N/A	40.65	126
Laboratory	55.73	N/A	55.73	157
Pharmacy	33.94	N/A	33.94	252
Physical Therapy				149
BEHAVIORAL				
Mental Health/Social Work				165.2
Social Work				
FACILITY SUPPORT				
Facility Management	126.86	N/A	126.86	100
PREVENTIVE				
Environmental Health				36.4
Health Education				22.4
Public Health Nursing				151.2
Public Health Nutrition				28
NUTRITION SUPPORT SERVICES				
Education & (egc1)				74
Group Consultation				
Education & (EGC)				19.8
Group Consultation				
Employee Facilities				186.48
Housekeeping & Linen (hl2)				56
Housekeeping & Linen (HL)	4.98	1.1	5.47	17.6
Property & Supply				323
Public Facilities				75.6
TOTALS		**Department Gross Square Meters**		**5082.52**
		Building Circulation & Envelope (.20)		**1016.5**
		Floor Gross Square Meters		**6099.02**
		Major Mechanical SPACE (.12)		**731.88**
		Building Gross Square Meters		**6830.9**

Appendices

Final 1/12/06

Mescalero
Service Unit

New Mexico

CL Associates, Inc.

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Santa Fe NM 87505

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Appendix A: Glossary

Glossary of Acronyms

AI	American Indian	JCAHO	Joint Commission on Accreditation of Healthcare Organizations
AN	Alaska Native	MCH	Maternal and Child Health
BIA	Bureau of Indian Affairs	NIHB	National Indian Health Board
CDC	Centers for Disease Control	NPIRS	National Patient Information Reporting System
CHA	Community Health Aide	OHPD	Office of Health Program Development
CHR	Community Health Representative	OTA	Office of Tribal Activities
CHS	Contract Health Services	PCC	Patient Care Component
COPC	Community-Oriented Primary Care	PHS	Public Health Service
DHHS	Department of Health and Human Services	PSA	Primary Service Area
ENT	Ear, Nose, and Throat	RPMS	Resource and Patient Management System
GPRA	Government Performance Reporting Act	RRM	Resource Requirements Methodology
HSP	Health Services Plan		
HUD	Housing & Urban Development		
IHPES	Indian Health Performance Evaluation System		
IHS	Indian Health Service		

Glossary of IHS Terms and Phrases

Active User Population

American Indians and Alaska Natives eligible for IHS services who have used those services at any IHS facility within the past three years. These numbers include all people who have ever registered to use a particular facility. The Active User Population of a Service Unit will reflect tribal members who are enrolled in tribes that belong to that particular Service Unit, regardless of where that person receives care throughout the IHS system nationwide. Active User Population also includes tribal members from tribes outside the Service Unit who have received care at a facility within the particular service unit. These numbers are not adjusted for deaths. It is the measure by which funds are allocated to a specific medical facility within the Service Unit, for both medical services and facilities support.

Area Office

A defined geographic region for Indian Health Service administrative purposes. Each Area Office administers several Service Units. In this case, the Albuquerque Area Office has management and coordination responsibilities for the nine Service Units.

Community Health Representative (CHR)

Indians selected, employed, and supervised by their tribes and trained by IHS to provide specific health care services at the community level.

Contract Health Services

Services not available directly from IHS or tribes that are purchased under contract from community hospitals and practitioners. CHS eligibility requirements: (1) must be a Native American or descendent from a federally-recognized Tribe; (2) must be a permanent resident of the county in which the Service Unit resides.

Government Performance and Results Act (GPRA)

A law requiring federal agencies to demonstrate effective use of funds in meeting their missions. The law requires agencies to have a five-year strategic plan (describing long-term goals) in place and to submit annual performance plans and reports (methods for accomplishing strategic plan using annual budget) with their budget requests.

Health Center

A facility, physically separated from a hospital, with a full range of ambulatory services, including at least primary care physicians, nursing, pharmacy, laboratory, and x-ray, that are available at least 40 hours a week for outpatient care.

Health Systems Plan

The HSP is designed to provide the documents necessary to plan and acquire approval for a medical program and then to communicate the necessary information to an Architect/Engineer for the design of a facility. This data is based on Active User Population and Projected User Population.

Health Station

A facility, physically separated from a hospital and health center, where primary care physician services are available on a regularly scheduled basis but for less than 40 hours a week.

Indian Health Performance Evaluation System (IHPES)

The IHPES appraises the quality of care and/or services provided by each participating facility by employing defined and measurable indicators. It is based on the hospital, ambulatory, and demographic information collected by the IHS Resource Patient Management System (RPMS) and provides a mechanism to meet the Joint Commission On Accreditation of Healthcare Organizations (JCAHO) ORYX initiative. The system also is used for the collection and measurement of indicators to meet the requirements of the Government Performance Results Act (GPRA).

Primary Service Area (PSA)

The geographic areas based on proximity in which IHS has responsibilities for planning and distributing health care resources "on or near" reservations; e.g., contract health service delivery areas.

Projected User Population

Based on the percentage of change in the 1990 – 2000 U.S. Census, population of the county where the reservation is located.

Q-Man

Database within RPMS system which contains disease-specific categorization by International Code of Disease (ICD-9).

Resource and Patient Management System (RPMS)

A standardized patient record system used exclusively by IHS to record patient data and provider workload.

Resource Requirements Methodology (RRM)

A computer spreadsheet program that is designed to project the staffing needs for a specific facility or primary service area. Its goal is to help ensure that IHS provides appropriate, reasonable and consistent staffing information to Congress and tribes. Information from the RRM is used in the development of Project Justification Documents (PJD), Project Summary Documents (PSD), or tribal requests for technical assistance in the submittal of HUD Block Grant Proposals.

Service Population

American Indians and Alaska Natives identified to be eligible for IHS services.

Service Unit

The local administrative unit of IHS, defined by geographic characteristics such as proximity of tribes and encompassing a defined Service Population.

Appendix B: Historical Information

Concerning Indian Health Care and the U.S. Commission on Civil Rights' Report: "Broken Promises"

History of Tribes and Medical Services Development

In November 1921, the U.S. Congress passed The Snyder Act (P.L. 94-482) to provide for, among other purposes, the benefit, care, and assistance of Indians throughout the U.S.

The Indian Health Service was created in 1955 to provide health services to Native Americans and Alaska Natives.

Beginning with the Indian Health Care Improvement Act (P.L. 94-437) of 1976, Congress was authorized to appropriate funds specifically for the health care of Indian people.

IHS MISSION: The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

IHS GOAL: To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

FOUNDATION of CARE: To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and culture and to honor and protect the inherent sovereign rights of Tribes.

This Act is considered for reauthorization every five years, providing opportunities for tribes and IHS administration to refine funding priorities in the hopes that Congress will increase appropriations to meet critical facility and service needs.

Annual budget appropriations provide operating revenue for hospitals, clinics, medical professionals, administrative staff, pharmacies, laboratories, and dental, mental health, diabetes education, and contracted health services to medical providers outside of the IHS system.

Three titles of the Indian Health Care Improvement Act (IHCIA) are of particular relevance: Title III, which covers health facilities; Title IV, which covers access to health services; and Title V, which covers health services to urban Indians.

Title III of the IHCIA focuses on ensuring that IHS facilities are fully capable of addressing the needs of the populations they are intended to serve. A number of proposed changes to the Act, as part of the reauthorization process, include consulting with tribes on facilities expenditures – with the goal of truly representing all unmet health care needs – as well as enabling smaller facilities to meet accreditation eligibility requirements for public insurance programs – with the goal of increasing health care services to tribal members. Other proposed changes have to do with increasing funding options to support the provision of health care services.

Title IV focuses on eliminating the barriers – social, logistical, financial – that prevent Indians from gaining access to and receiving public health care and that also limit reimbursement from third-party payers. Proposed changes under the reauthorization process include: authorizing reimbursement to IHS facilities for all Medicare/Medicaid-covered services; waiving all cost-sharing by IHS-eligible patients enrolled in public insurance programs; and waiving Medicare's late enrollment fee.

Title V focuses on improving the health status of urban Indians. Proposed changes focus on enhancing the U.S. Department of Health and Human Services (HHS)' authority to fund urban Indian health programs through a variety of means, such as grants and loans.

Another piece of federal legislation that is relevant to this plan is the Indian Self-Determination Act Amendments of 1994 (P.L. 103-413), which amend the Indian Self-Determination and Education Act (P.L. 93-638), a law giving tribes the authority to contract for the direct operation of programs serving their members. Title I of P.L. 103-413 significantly amends P.L. 93-638 by simplifying contracts entered into between the United States government and Indian tribes and tribal organizations. In particular, regulations published jointly by HHS and the Department of the Interior to implement P.L. 103-413 aimed at greatly reducing the paperwork required of Indian tribes applying to contract with HHS. The contracting process often is referred to in shorthand as the "638 process," in recognition of the original law.

It is important, however, to put these laws into context. Despite a legal and regulatory framework, "persistent discrimination and neglect continue to deprive Native Americans of a health system sufficient to provide health care equivalent to that provided to the vast majority of Americans," state the authors of "Broken Promises: Evaluating the Native American Health Care System." This report, drafted in July 2004 by the U.S. Commission on Civil Rights' Office of the General Counsel, details social, cultural, structural, and financial barriers that both limit Indians' access to health care and contribute to health disparities and also offers recommendations to close the health care gap for Indians, whether living in rural areas or in towns and cities across the United States.

Among the significant themes repeated in “Broken Promises” is the extent to which the health status of Indians is declining in relation to the general population. One finding is particularly relevant and poignant: Type 2 diabetes, once a disease afflicting adults, now is making a dramatic appearance among Indian youth, which only hastens the likely development of other serious and costly complications.

The report also emphasizes the causal relationship between poverty and substandard housing conditions – realities that many Indians face – and serious health effects. “Because Native Americans have the highest poverty and unemployment rates, their health is inevitably compromised,” the report’s authors state. Compounding this situation is another formidable barrier: limited access to health care services. For example, many Indians live in remote areas where roads can become impassable during certain times of the year, transportation is lacking, and facilities are under-equipped to provide diagnoses or services.

One positive step to addressing these and related deficiencies is IHS’ efforts to involve tribes in determining the location of IHS facilities and the kinds of services needed. In addition to the HSFMP, the Facilities Appropriation Advisory Board has provided input to the IHS on development of a facilities prioritization process that will result in a revised methodology for determining funding for facility renovation or replacement.

Appendix C: MSU Strengths, Weaknesses, Opportunities, Threats

At time of printing, there was insufficient data or data was inaccessible to CL Associates for this Appendix.

Appendix D: Points of Contact

Mescalero Service Unit Points of Contact

Name	Title Organization Facility	Address Mail & Physical Address	Telephone Fax Email
Albuquerque Area - Headquarters			
James Toya	Director, ABQ Area IHS	5300 Homestead Rd, NE Albuquerque, NM 87034	505/248-8003
Russ Pederson	Director, OEHE IHS	5300 Homestead Rd, NE Albuquerque, NM 87034	505/248-4275 505/248-4678 rpederson@ihs.abq.gov
Darrell LaRoche	Director, Health Facilities IHS	5300 Homestead Rd, NE Albuquerque, NM 87034	505/248-4947 dlaroche@ihs.abq.gov
Mescalero Service Unit Staff			
Matt Anderson	Chief Executive Officer (2005)	PO Box 210 Mescalero, NM 88340	505/464-4441 manderson@abq.ihs.gov
Pearlita La Paz	Acting Chief Executive Officer (2004); Director, Managed Care (2005)	PO Box 210 Mescalero, NM 88340	505/464-4441 plapaz@abq.ihs.gov
Dr. Shauna Marie Paylor	Acting Clinical Director Mescalero Service Unit	PO Box 210 Mescalero, NM 88340	505/464-4441 X 115 spaylor@abq.ihs.gov
Sylvia Smart	Coordinator, Risk Management	PO Box 210 Mescalero, NM 88340	505/464-4441 X 103 ssmart@abq.ihs.gov
Joe Glass	Psychologist	PO Box 210 Mescalero, NM 88340	505/464-4441 X 124
Yolanda Adams	Director of Nursing	PO Box 210 Mescalero, NM 88340	505/464-4441 X 179
Charlotte Briggs	Public Health Nursing Services Director	PO Box 210 Mescalero, NM 88340	505/464-4441 X 159
Rainey Enjady	Budget Director	PO Box 210 Mescalero, NM 88340	505/464-4441 X 104
Vonda Tso	Patient Registration	PO Box 210 Mescalero, NM 88340	505/464-4441 X 109
Suzanna Duran	Laboratory Director, Supervisor Medical Technician	PO Box 210 Mescalero, NM 88340	505/464-4441 X 140
Dr. Phil Zinser, DDS	Dental Supervisor	PO Box 210 Mescalero, NM 88340	505/464-4441 X 131
Idella Starr	Benefits Coordinator	PO Box 210 Mescalero, NM 88340	505/464-4441 X 112 istarr@abq.ihs.gov

Continued…

Melvin Horton / Hugh Evans	General Services	PO Box 210 Mescalero, NM 88340	505/464-4441 X 168
Maybelle Holiday	Supervisor, Diagnostic Radiology	PO Box 210 Mescalero, NM 88340	505/464-4441 X 146
Renae Rice	Contract Health Services	PO Box 210 Mescalero, NM 88340	505/464-4441 X 128
Amy Maupin	Chief Dietician	PO Box 210 Mescalero, NM 88340	505/464-4441 X 161
Kathleen Murphy	Computer Systems Analyst/Site Manager	PO Box 210 Mescalero, NM 88340	505/464-4441 X 164
Malena Jones	Chief Pharmacist	PO Box 210 Mescalero, NM 88340	505/464-4441 X 143
Dr. Thomas Raffaele, MD	Optometrist & Safety Officer	PO Box 210 Mescalero, NM 88340	505/464-4441 X 135
Mescalero Service Unit Health Board / Tribal Council Members			
Glenda Brusuelas	Mescalero Tribal Council Member	PO Box 588 Mescalero, NM 88340	505/464-4494 work fax: 505/671-4742 home: 505/671-4741
Alta M. Branham	Mescalero Tribal Council Member	101 Magoosh Drive Mescalero, NM 88340	505/464-9674 home 505/464-4180 work abranham@imgresort.com alta@matisp.net
Larry Shaub	Mescalero Tribal Council Member	P.O. Box 227 Mescalero, NM 88340	

Appendix E: Results of Interviews with Key MIH Staff

INSTRUCTIONS:

When constructing and collating the document, please REMOVE THIS PAGE and REPLACE it with the separate document described here:

Results of Interviews with Key Staff,

an 11x17“ spreadsheet printed separately and folded accordian style to fit into 81/2x11” sized binder

Appendix F: Clinic Services and Frequency of MIH Clinics

During the preparation of this Plan, the hours and services changed for the Service Unit facilities. Therefore, it was determined best not to list this information. For hours and services available, please contact the facility.

Appendix G: List of additional facilities within 50 miles

MESCALERO Service Unit P.O. BOX 210/301 Sage Ave, Mescalero, NM 88340

LIST OF ADDITIONAL FACILITIES WITHIN 50 MILES OF MSU

CLINICS	CITY	DISTANCE
WITHIN 20 MILES		
Lcmc – Geriatric Psychiatric	Ruidoso	16
Lincoln County Pregnancy Center	Ruidoso	16
Mental Health Counseling Center	Ruidoso	16
PMS Home Health & Hospice of Lincoln County	Ruidoso	16
White Mountain Medical Offices	Ruidoso	16
Alcoholics Anonymous & Al-Non	Ruidoso	17
Lincoln County Medical Center	Ruidoso	17
Lincoln County Medical Center for Senior Adults	Ruidoso	17
Substance Abuse Services	Ruidoso	17
Tularosa Medical Center	Tularosa	17
Family Practice Associates of Ruidoso	Ruidoso	18
Ruidoso Gastroenterology	Ruidoso	18
Casa Alegre	Ruidoso	19
Crossroad Counselors	Ruidoso	19
Ruidoso Care Center	Ruidoso	19
Ruidoso Health OFC	Ruidoso	19
St. Claire Kamerin	Ruidoso	19
Immediate Care Clinic and Family Practice	Ruidoso	20
Mirasol Counseling	Ruidoso	20
Presbyterian Medical Center	Cloudcroft	20
Aristocrat Special Care Center	Alamogordo	28
Betty Dare Good Samaritan Center	Alamogordo	28
Gerald Champion Regional Medical Center	Alamogordo	29
Recovery Outreach	Alamogordo	29

CLINICS	CITY	DISTANCE
WITHIN 30 MILES		
Alamogordo Mental Health Services	Alamogordo	30
Alamogordo Nephrology	Alamogordo	30
Health Otero Public Health Office	Alamogordo	30
Immediate Care Center	Alamogordo	30
Independent Counselor Offices	Alamogordo	30
La Francoise	Alamogordo	30
Mental Health Intervention Consortium	Alamogordo	30
Renal Care Group	Alamogordo	30
V A Clinic	Alamogordo	30
White Sands Family	Alamogordo	30
White Sands Mental Health	Alamogordo	30
AA Alcoholics Anonymous	Alamogordo	31
Adamh Counseling Services	Alamogordo	31
Alamogordo Physical Therapy - Clinic	Alamogordo	31
Alliance Behavioral Health SVCS of Southern NM	Alamogordo	31
Ben Archer Health Center	Alamogordo	31
Better Balance Counseling Services	Alamogordo	31
The Counseling Center	Ruidoso	31
The Counseling Center – Outpatient Services	Alamogordo	31
Rose Medical Clinic	Capitan	36
C H I N S – Children in Need of Services	Alamogordo	38

HOSPITALS	CITY	DISTANCE
WITHIN 20 MILES		
Lincoln County Medical Center	Ruidoso	17
Family Practice Associates of Ruidoso	Ruidoso	18
Gerald Champion Regional Medical Center	Alamogordo	29
WITHIN 30 MILES		
Alamogordo Physical Therapy - Clinic	Alamogordo	31
The Rose Clinic	Capitan	37

NURSING CARE FACILITIES	CITY	DISTANCE
ASSISTED LIVING FACILITIES		
WITHIN 30 MILES		
Aristocrat Assisted Living Center	Alamogordo	28
La Francoise	Alamogordo	30
HOSPICE		
WITHIN 20 MILES		
Ruidoso Home Care & Hospice	Ruidoso	21
WITHIN 30 MILES		
Alamogordo Home Health Care Hospice	Alamogordo	30
NURSING & PERSONAL CARE		
La Francoise	Alamogordo	30

Appendix H-1:MSU 2004 Outpatient Visit Volume by Diagnoses

Group	Visits	% of Total
Mental Disorders	**2,130**	**8%**
Diseases of the Musculoskeletal and Connective Tissue	**1,663**	**6%**
Injury and Poisoning	1,628	6%
Infectious and Parasitic Disease	1,299	5%
Symptoms, Signs, and Ill-defined conditions	**1,100**	**4%**
Diseases of the Digestive System	1,096	4%
Diseases of the Skin and Subcutaneous Tissue	966	4%
Diseases of the Genitourinary System	724	3%
Diseases of the Circulatory System	505	2%
Diseases of the Blood and Blood-Forming Organs	135	1%
Neoplasms	112	0%
Complications of Pregnancy, Childbirth, and the Puerperium	81	0%
Certain Conditions Originating in the Perinatal Period	41	0%
Congenital Anomalies	31	0%
Other / Supplemental	14,685	56%
Prescriptions	**6,522**	**25%**
Dental	**2,440**	**9%**
Lab	57	0%
eye	134	1%
Vaccination	658	3%
Pregnancy	749	3%
Routine Infant or Child Health Check	759	3%
Contraception	654	2%
Other Encounter for Administrative Purposes	47	0%
GYN Exam	296	1%
Health Education / Instruction	78	0%
Health Exams of Defined Subpops	410	2%
TB	119	0%
Other medical exam for admin purposes	90	0%
PT		0%
Dietary	203	1%
Radiological exam	4	0%
Other	1,465	6%
Total	**26,196**	**100%**

Source: IHPES

Appendix H-2: Outpatient Visit Volume by Age Group

2004 Patient Visits by Primary, Secondary, and Tertiary Diagnostic Groups

CL Associates, Inc.

MESCALERO IH

Diagnosis #	Diagnostic Category	0	1-14	15-44	45-64	65+	Total		% of Total					
									Diagnostic Group	0	1-14	15-44	45-64	65+
Primary	Other / Supplemental	398	2,792	6,593	3,618	1,284	14,685		43%	3%	19%	45%	25%	9%
	Diseases of the Respiratory System	196	1,201	1,407	508	104	3,416		10%	6%	35%	41%	15%	3%
	Diseases of the Nervous System and Sense Organs	174	936	898	427	120	2,555		8%	7%	37%	35%	17%	5%
	Mental Disorders		422	1,284	396	28	2,130		6%	0%	20%	60%	19%	1%
	Endocrine, nutritional, metabolic diseases, and immunity disorders	4	24	529	699	408	1,664		5%	0%	1%	32%	42%	25%
	Diseases of the Musculoskeletal and Connective Tissue		58	920	582	103	1,663		5%	0%	3%	55%	35%	6%
	Injury and Poisoning	14	403	913	244	54	1,628		5%	1%	25%	56%	15%	3%
	Infectious and Parasitic Disease	36	411	582	212	58	1,299		4%	3%	32%	45%	16%	4%
	Symptoms, Signs, and Ill-defined conditions	30	144	619	248	59	1,100		3%	3%	13%	56%	23%	5%
	Diseases of the Digestive System	69	217	519	245	46	1,096		3%	6%	20%	47%	22%	4%
	Diseases of the Skin and Subcutaneous Tissue	33	231	437	189	76	966		3%	3%	24%	45%	20%	8%
	Diseases of the Genitourinary System	6	46	443	169	60	724		2%	1%	6%	61%	23%	8%
	Diseases of the Circulatory System		4	195	182	124	505		1%	0%	1%	39%	36%	25%
	Diseases of the Blood and Blood-Forming Organs		21	51	40	23	135	% of	0%	0%	16%	38%	30%	17%
	Neoplasms		1	44	47	20	112	Patients	0%	0%	1%	39%	42%	18%
	Complications of Pregnancy, Childbirth, and the Puerperium		4	77			81	with	0%	0%	5%	95%	0%	0%
	Certain Conditions Originating in the Perinatal Period	39	2				41	Primary	0%	95%	5%	0%	0%	0%
	Congenital Anomalies	1	9	10	9	2	31	Diagnosis	0%	3%	29%	32%	29%	6%
Primary Total		**1,000**	**6,926**	**15,521**	**7,815**	**2,569**	**33,831**	**100%**	**100%**	**3%**	**20%**	**46%**	**23%**	**8%**
Secondary	Endocrine, nutritional, metabolic diseases, and immunity disorders	7	61	798	1,063	534	2,463		15%	0%	2%	32%	43%	22%
	Diseases of the Respiratory System	145	859	868	420	75	2,367		14%	6%	36%	37%	18%	3%
	Other / Supplemental	72	231	1,130	240	81	1,754		11%	4%	13%	64%	14%	5%
	Mental Disorders		231	876	437	88	1,632		10%	0%	14%	54%	27%	5%
	Diseases of the Nervous System and Sense Organs	52	431	617	364	84	1,548		9%	3%	28%	40%	24%	5%
	Diseases of the Musculoskeletal and Connective Tissue		21	642	477	121	1,261		8%	0%	2%	51%	38%	10%
	Diseases of the Circulatory System	1	8	317	469	289	1,084		7%	0%	1%	29%	43%	27%
	Diseases of the Digestive System	27	95	424	340	119	1,005		6%	3%	9%	42%	34%	12%
	Symptoms, Signs, and Ill-defined conditions	28	101	484	271	66	950		6%	3%	11%	51%	29%	7%
	Diseases of the Skin and Subcutaneous Tissue	40	110	266	162	50	628		4%	6%	18%	42%	26%	8%
	Infectious and Parasitic Disease	18	94	309	134	31	586		4%	3%	16%	53%	23%	5%
	Diseases of the Genitourinary System	3	16	290	175	69	553		3%	1%	3%	52%	32%	12%
	Injury and Poisoning	4	65	165	69	19	322		2%	1%	20%	51%	21%	6%
	Diseases of the Blood and Blood-Forming Organs		15	99	47	36	197	% of	1%	0%	8%	50%	24%	18%
	Complications of Pregnancy, Childbirth, and the Puerperium		1	65			66	Patients	0%	0%	2%	98%	0%	0%
	Neoplasms	1		30	19	11	61	with	0%	2%	0%	49%	31%	18%
	Congenital Anomalies	6	20	8	7	1	42	Secondary	0%	14%	48%	19%	17%	2%
	Certain Conditions Originating in the Perinatal Period	9	6				15	Diagnosis	0%	60%	40%	0%	0%	0%
Secondary Total		**413**	**2,365**	**7,388**	**4,694**	**1,674**	**16,534**	**49%**	**100%**	**2%**	**14%**	**45%**	**28%**	**10%**
Tertiary	Diseases of the Respiratory System	36	265	297	216	42	856		16%	4%	31%	35%	25%	5%
	Endocrine, nutritional, metabolic diseases, and immunity disorders	2	17	215	333	137	704		13%	0%	2%	31%	47%	19%
	Diseases of the Nervous System and Sense Organs	13	114	169	206	67	569		11%	2%	20%	30%	36%	12%
	Mental Disorders		66	243	181	30	520		10%	0%	13%	47%	35%	6%
	Diseases of the Circulatory System			131	218	126	475		9%	0%	0%	28%	46%	27%
	Other / Supplemental	3	47	246	88	34	418		8%	1%	11%	59%	21%	8%
	Diseases of the Musculoskeletal and Connective Tissue		10	152	176	56	394		7%	0%	3%	39%	45%	14%
	Diseases of the Digestive System	12	38	135	138	51	374		7%	3%	10%	36%	37%	14%
	Symptoms, Signs, and Ill-defined conditions	7	19	113	103	19	261		5%	3%	7%	43%	39%	7%
	Diseases of the Genitourinary System	1	5	99	62	26	193		4%	1%	3%	51%	32%	13%
	Diseases of the Skin and Subcutaneous Tissue	5	29	76	53	11	174		3%	3%	17%	44%	30%	6%
	Infectious and Parasitic Disease	2	25	77	50	14	168		3%	1%	15%	46%	30%	8%
	Injury and Poisoning		15	64	23	4	106		2%	0%	14%	60%	22%	4%
	Diseases of the Blood and Blood-Forming Organs		4	44	16	19	83	% of	2%	0%	5%	53%	19%	23%
	Neoplasms			13	7	5	25	Patients	0%	0%	0%	52%	28%	20%
	Complications of Pregnancy, Childbirth, and the Puerperium			18			18	with	0%	0%	0%	100%	0%	0%
	Congenital Anomalies		2	1	2	2	7	Tertiary	0%	0%	29%	14%	29%	29%
	Certain Conditions Originating in the Perinatal Period	1					1	Diagnosis	0%	100%	0%	0%	0%	0%
Tertiary Total		**82**	**656**	**2,093**	**1,872**	**643**	**5,346**	**16%**	**100%**	**2%**	**12%**	**39%**	**35%**	**12%**

Appendix H-3: Top 50 Diagnoses

	MESCALERO			2004	1999-2004
2004 RANK	**ICD DIAGNOSIS NAME**	**1999**	**2004**	**% of Total**	**% Change**
1	Issue Repeat Prescript	3,157	6,522	19%	107%
2	Dental Examination	1,834	2,440	7%	33%
3	Acute Uri Nos	1,344	1,119	3%	-17%
4	Diab Uncomp Typ Ii/Niddm	672	1,031	3%	53%
5	Otitis Media Nos	641	920	3%	44%
6	Routin Child Health Exam	650	759	2%	17%
7	Vaccine And Inocula Influenza		658	2%	
8	Allergic Rhinitis Nos	148	498	1%	236%
9	Supervis Oth Normal Preg	510	495	1%	-3%
10	Myopia	242	436	1%	80%
11	Health Exam-Group Survey	34	410	1%	1106%
12	Acute Pharyngitis	452	393	1%	-13%
13	Noninf Gastroenterit Nec	297	382	1%	29%
14	Chronic Sinusitis Nos	191	381	1%	99%
15	Depressive Disorder Nec	179	352	1%	97%
16	Bronchitis Nos	210	349	1%	66%
17	Gynecologic Examination	203	296	1%	46%
18	Contraceptive Mangmt Nos	58	289	1%	398%
19	Urin Tract Infection Nos	210	264	1%	26%
20	Attn Deficit W Hyperact	177	255	1%	44%
21	Hypertension Nos	211	250	1%	18%
22	Panic Disorder	146	240	1%	64%
23	Adjustment Reaction Nos	54	230	1%	326%
24	Prophylactic Measure Nos	369	220	1%	-40%
25	Supervis Normal 1st Preg	90	214	1%	138%
26	Backache Nos	104	206	1%	98%
27	Dietary Surveil/Counsel	16	203	1%	1169%
28	Dermatitis Nos	133	199	1%	50%
29	Strep Sore Throat	70	198	1%	183%
30	Abdominal Pain, Uns Site	220	197	1%	-10%
31	Astigmatism Nos	124	193	1%	56%
32	Recurr Depr Psychos-Mod	49	192	1%	292%
33	Contracept Pill Surveill	109	184	1%	69%
34	Hypermetropia	67	181	1%	170%
35	Alcoh Dep Nec/Nos-Unspec	96	173	1%	80%
36	Asthma Unspecified	126	165	0%	31%
37	Contracept Surveill Nec	180	163	0%	-9%
38	Lumbago	142	151	0%	6%
39	Pain In Limb	28	146	0%	421%
40	Infec Otitis Externa Nos	41	136	0%	232%
41	Eye & Vision Examination	21	131	0%	524%
42	Unspec Viral Infections	214	128	0%	-40%
43	Rheumatoid Arthritis	48	125	0%	160%
44	Esophageal Reflux	61	120	0%	97%
45	Headache	134	120	0%	-10%
46	Diab Uncontrol, Type Ii	22	119	0%	441%
47	Acute Sinusitis Nos	71	118	0%	66%
48	Screening-Pulmonary Tb	133	117	0%	-12%
49	Cellulitis Of Leg	97	110	0%	13%
50	Family Circumstances Nec	15	108	0%	620%
	All Other	11,907	10,545	31%	-11%
		26,307	**33,831**	**100%**	**29%**

Appendix I: Questions Presented to Health Board

Mescalero Service Unit Master Plan Questionnaire

Health Board and Tribal Consultation Questions

General Questions for Discussion

1. What characteristics and services of the MSU should determine priority for funding?
    a. Distance to care – how it affects access to care.
    b. Number of patients who actually use the MIH / clinic services.
    c. Quality of health and incidence of disease – review historical epidemiology statistics.
    d. Quality of care vs. proximity to care—are issues of quality of care more or less important than convenience/location of service?
    e. Others … ?

2. Which of the services that MIH presently refers out, or contracts for services, do you believe could be adequately located in the MIH – ***See CHS Summary***

3. How can we improve the health care delivery of the MSU area? Be specific about improvements.
    a. How to improve existing services within the hospital and the clinics?
    b. New services within the hospital and the clinics?
        i. What <u>is</u> being considered?
        ii. What <u>should</u> be considered?
    c. Improved facilities / MIH and clinics ?
    d. New facilities / MIH and clinics?
    e. Service improvements
        i. Improve/revive MIH in-patient services, surgeries, etc.
        ii. Close MIH in-patient and expand contract services.

4. Are there communities or geographic groups of communities that are specifically underserved in relationship to access to primary care?
   Please list.

5. Should we re-define the communities and the service centers they fall under? Is everyone included?

6. What is the best strategy to provide care for the urban Indians?

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Appendix J: List of Service Desired by MSU Health Board

Mescalero	LEVEL OF CARE BY DISTANCE							
Health Service	Services should be provided at MSU Hospital or Clinic	Fulltime Position	Parttime Position	Services should be provided within **24** miles or less	Services should be provided within **59** miles or less	Services should be provided withint **94** miles or less	Services should be provided within **129** miles or less	Services should be provided within **180** miles or less
Physician Care								
Family Practice	x							
Internal Medicine	x							
Pediatric	x							
Gynecology	x							
Dermatology	x							
Orthopedics	x				S			
Gerontology	x							UNM
Opthamology					x			
Radiologists	x							
General Surgery				x				
Otolaryngology					x			
Cardiology					x		S	
Urology				x				
Neurology					x			
Nephrology	C				S			
Allergy							x	
Pulmonology								UNM
Gastroenterology				x				
Rheumatology	C						x	
Oncology					x			
Traditional Healing	x							
Pediatric Subspecialities								UNM
Dental	x							
Oral Surgery								x
Labor & Delivery – birthing center	x							
EMERGENCY / ICU								
After Hours Urgent Care								
Emergency	x							
Ground Ambulance	x							
Air Ambulances: Rotor								
Air Ambulance: Fixed								
AMBULATORY CARE SERVICES								
Nutrition	x							
Optometry	x							
Podiatry	x							
Dialysis	x							
Audiology	x							
Chiropractic	x							
Acupuncture	x							

BEHAVIORAL HEALTH								
Psychiatry	x							
Mental Health	x							
Social Services	x							
Alcohol & Substance Abuse - After Care, Rehab, Follow-up	Rehab Unit							
Substance Abuse Transitional Care	Rehab Unit							
Medical Detox	x							
ELDER CARE								
Skilled Nursing	Nursing Home							
Assisted Living	Nursing Home							
Hospice	Nursing Home							
Home Health Care	x							
WELL BABY/WELL CHILD								
Post partum baby checks	x							
Vaccinations	x							
PREVENTIVE MEDICINE								
Diabetes	x							
Hypertension	x							
ANCILLARY SERVICES								
Staffed Pharmacy	x							
Lab Specimen Collection	x							
Clinical Lab	x							
Microbiology Lab				x				
Anatomical Pathology				x				
X-Rays	x							
Ultrasound Level I	x							
Fluroscopy				x				
CT				x				
MRI				x				
Nuclear Medicine					x			
Radiation Oncology					x			
Medical Oncology (Chemo)					x			
Physical Therapy	x							
Occupational Therapy	x							
Speech Therapy	x							
Respiratory Therapy	x							
Outpatient Endoscopy				x				
Outpatient Surgery				x				
Inpatient Surgery				x				

WOMEN'S CARE								
Mammography				x				
Screening Mammography				x				
Ultrasound – OB	x							
Pap smears	x							
STD treatment / counseling	x							
Birth Control counseling	x							
MEN'S CLINICS								
Prostate screening	x							
STD treatment / counseling	x							
Birth Control counseling	x							
INPATIENT CARE								
Labor & Delivery	x							
Labor & Delivery – low risk	x							
Labor & Delivery – high risk								UNM
Medical Inpatient	x							
Surgical Inpatient				x				
Pediatric	x							
Intensive Care				x				
Sub Acute / Transitional Care	x							
Acute Dialysis					x			
Adolescent Substance Abuse	x							
Adult Substance Abuse	x							
Psychiatric								x
Psychiatric – low acuity								x
Psychiatric – high acuity								x
OTHER SERVICES								
Case Management	x							
Environmental Health	x							
Transportation	x							
Public Health Nursing	x							
Public Health Nutrition	x							
Health Education	x							
School Education - dental	x							
School Education - prevention	x							
After Hour & Weekend clinics	x							
Daibetes Clinics	x							
Epidemiology Services	x							
Coding and Medical Records	x							
Benefits Coordinator	x							
Adult and Child Protection, Intervention	x							

Appendix K: Staffing Needs Summary

Appendix K: MSU Staffing Needs Summary PRELIMINARY & Pending Staff Input

2105 RRM based on Projected Active User Population of 5,147 Patients

2004 User Population	*4467*	*2004 Non-SFSU Tribal User Population*	*840*
2004 Outpatient Visits	*34,173*	*2004 Laboratory Tests*	
2004 Inpatient Visits	*41*	*2004 Laboratory Visits*	
***2003** Optometry visits*	*863*	*2003 Dental Visits*	*2436*
2004 Pharmacy visits	*6627*	*2004 Dental Patients*	*1305*
2004 Prescriptions - new refills	*5083*	*2004 Xray Exams*	*87*
***2003** Pharmacy Perscriptions*	*37,245*		

* Information from providers and based on observation of use

			2004 Staffing	Needed for Current Use	Unfilled Positions / Vacancies	2015 Need From 2003 RRM	2015 Need Based on Use Projection
INPATIENT CARE							
	INPATIENT PHYSICIANS						
		Chief of Service				0.08	
		GM Physician				0.53	
		Peds. Physician				0.00	
		OB/GYN Physician				0.00	
		Clerical Support				0.13	
		Subtotal:	**0**	**0**	**0**	**0.74**	**0**
	SURGEONS						
		General Surgeon				0.00	
		OB/GYN Surgeon				0.00	
		Nurse/Midwife				0.00	
		Anesthesiologist				0.00	
		Subtotal:	**0**	**0**	**0**	**0.00**	**0**
	NURSING						
		Nursing Administration				0.00	
		Admin. Clerical Support				0.00	
		GM/SURG-Registered Nurse				0.00	
		GM/SURG - LPN/Technician				0.00	
		GM/SURG - Clerical Support				0.00	
		PED-Registered Nurse				0.00	
		PED-LPN/Technician				0.00	
		PED - Clerical Support				0.00	
		OB/L&D - Registered Nurse				0.00	
		OB/L&D - LPN/Technician				0.00	
		OB/L&D - Clerical Support				0.00	
		Newborn - LPN/Technician				0.00	
		Newborn - Clerical Support				0.00	
		Nursery, RN, Fixed				0.00	
		Nursery, LPN/Technician				0.00	
		Nursery, Clerical Support				0.00	
		ICU, RN				0.00	
		ICU, Clerical Support				0.00	
		Step-Down Unit, RN				0.00	
		Step-Down Unit, LPN				0.00	
		Step-Down Unit, Clerical Support				0.00	
		OR RN				0.00	
		OR, LPN/Technician				0.00	
		Post Anesthesia Recovery, RN				0.00	
		Ambulatory Surgery, RN				0.00	
		Psych-RN, Fixed				0.00	
		Psych, LPN/Technician				0.00	
		Psych, Clerical Support				0.00	
		Quality Improvement Nurse				0.00	
		Discharge Planning Nurse				0.00	
		Observ. Bed - Registered Nurse				0.00	
		Patient Escort, RN				0.00	
		Nurse Educator				0.00	
		Subtotal:	**0**	**0**	**0**	**0.00**	**0**
	INPATIENT DEVIATIONS						
		INP_DEV1				0.00	
		Subtotal:	**0**	**0**	**0**	**0.00**	**0**
	SUBTOTAL-Inpatient Services					**0.00**	

			2004 Staffing	Needed for Current Use	Unfilled Positions / Vacancies	2015 Need From 2003 RRM	2015 Need Based on Use Projection
AMBULATORY CARE							
	EMERGENCY						
		ER/After Hours Staff				1.86	
		ER RN Supervisor				0.00	
		ER Medical Clerks				0.00	
		RNs, ER				0.00	
		Subtotal:	**0**	**0**	**0**	**1.86**	**0**
	AMBULATORY PHYSICIAN						
		Primary Care Provider	3	6	1	6.92	
		Specialty Care Provider				0.18	
		Primary Care Provider (CHA/P)				0.00	
		Physician Assistant	2			0.00	
		Clerical Support	1			1.62	
		Subtotal:	**6**	**6**	**1**	**8.72**	**0**
	AMBULATORY SURGERY						
		General Surgeon				0.00	
		Subtotal:	**0**	**0**	**0**	**0.00**	**0**
	NURSING AMBULATORY / IN-PATIENT **						
		Nurse Supervisory (in hosp.OPD)	1			1.00	
		Medical Clerk, Exec. Support				1.00	
		Nurse Manager	1			2.09	
		RN, Core Activities	10			8.74	
		LPN	5			2.91	
		Clerical Support				2.74	
		Infection Control Nurse	1			0.00	
		NA / MST	1			0.00	
		Subtotal:	**19**	**0**	**0**	**18.48**	**0**
	EYE CARE						
		Optometrist	1			1.10	
		Optometric Assistant				1.07	
		Optometric Technician	1			1.07	
		Ophthalmologist				0.00	
		Opthalmologist Assistant				0.00	
		Subtotal:	**2**	**0**	**0**	**3.24**	**0**
	AUDIOLOGY						
		Audiologist				0.00	
		Audiometric Technician	0.1			0.00	
		Subtotal:	**0.1**	**0**	**0**	**0.00**	**0**
	PHYSICAL THERAPY						
		Physical Therapist				0.89	
		Occupational Therapist					
		Subtotal:	**0**	**0**	**0**	**0.89**	**0**
	CLERICAL POOL						
		PT, Audiology & Eye Care				0.83	
		Subtotal:	**0**	**0**	**0**	**0.83**	**0**
	DENTAL						
		Dentist	1.25	2		6.22	
		Dental Assistant	2	3		12.44	
		Dental Hygienist				1.55	
		Clerical Support				1.87	
		Subtotal:	**3.25**	**5**	**0**	**22.08**	**0**
	AMBULATORY DEVIATIONS & Notes						
		Ambulatory Dev1				0.00	
		Ambulatory Dev2				0.00	
	**	1 - 1 1/2 RNs on inpatient duty, 12 hour shifts				0.00	
		Subtotal:	**30.35**			**0.00**	
	SUBTOTAL - Ambulatory Clinics		**60.70**	**11.00**	**1.00**	**56.10**	**0.00**

	2004 Staffing	Needed for Current Use	Unfilled Positions / Vacancies	2015 Need From 2003 RRM	2015 Need Base on Use Projection
CLINICAL SUPPORT (ANCILLARY SERVICES)					
LABORATORY					
Medical Technologist	1			2.76	
Medical Technician (CHA/P)	4			0.00	
Medical Technician				2.01	
Subtotal:	**5**	**0**	**0**	**4.77**	**0**
PHARMACY					
Pharmacist	3			6.68	
Pharmacist (CHA/P)				0.00	
Pharmacy Technician	1			2.28	
Subtotal:	**4**	**0**	**0**	**8.96**	**0**
DIAGNOSTIC IMAGING					
Imaging Technologist	1			2.37	
Imaging Technologist (CHA/P)	1			0.00	
Subtotal:	**2**	**0**	**0**	**2.37**	**0**
MEDICAL RECORDS					
Medical Records Administrator	1			1.00	
Medical Records Technician	4			7.29	
Medical Records Technicial (CHA/P)				0.00	
PCC Supervisor				0.81	
PCC Data Entry Personnel	2			3.24	
PCC Data Entry Personnel (CHA/P)				0.00	
Coder				4.09	
Medical Runner				0.36	
Subtotal:	**7**	**0**	**0**	**16.79**	**0**
RESPIRATORY THERAPY					
Respiratory Staff				0.00	
Subtotal:	**0**	**0**	**0**	**0.00**	**0**
CLERICAL POOL					
Lab, Pharmacy & Imaging				0.83	
Subtotal:	**0**	**0**	**0**	**0.83**	**0**
ANCILLARY DEVIATIONS					
ANCIL_DEV1				0.00	
ANCIL_DEV2				0.00	
ANCIL_DEV3				0.00	
ANCIL_DEV4				0.00	
Subtotal:	**0**	**0**	**0**	**0.00**	**0**
SUBTOTAL - Ancillary Services	**18.00**	**0.00**	**0.00**	**33.72**	**0.00**
COMMUNITY HEALTH					
PUBLIC HEALTH NUTRITION					
Nutritionist	1			1.84	
Subtotal:	**1**	**0**	**0**	**1.84**	**0**
PUBLIC HEALTH NURSING					
Public Health Nurse Manager				1.00	
Public Health Nurse	2			6.51	
Public Health Nurse - School				0.00	
Clerical Support				0.82	
Subtotal:	**2**	**0**	**0**	**8.33**	**0**
HEALTH EDUCATION					
Public Health Educator				1.29	
Subtotal:	**0**	**0**	**0**	**1.29**	**0**
OFC OF ENVIRONMENTAL HEALTH & ENGRG					
OEHE RRM				1.00	
Subtotal:	**0**	**0**	**0**	**1.00**	**0**
SUBTOTAL - Community Health				**12.46**	

			2004 Staffing	Needed for Current Use	Unfilled Positions / Vacancies	2015 Need From 2003 RRM	2015 Need Based on Use Projection
BEHAVIORAL HEALTH SERVICES							
	MENTAL HEALTH						
		Mental Health Staff	3			2.97	
		Subtotal:	**3**	**0**	**0**	**2.97**	**0**
	SOCIAL SERVICES						
		MSW Counselor Inpatient Only				0.09	
		Social Service Staff				1.84	
		Subtotal:	**0**	**0**	**0**	**1.93**	**0**
	CLERICAL POOL						
		Behavioral Health	1			0.83	
		Subtotal:	**1**	**0**	**0**	**0.83**	**0**
	RRM DEVIATIONS - COMMUNITY HEALTH						
		Psychiatrist	0.5			0.00	
		Mental Health Technician	1	1		0.00	
		CM_DEV3				0.00	
		CM_DEV4				0.00	
		CM_DEV5				0.00	
		CM_DEV6				0.00	
		Subtotal:	**1.5**	**1**	**0**	**0.00**	**0**
	SUBTOTAL - Behavioral Health Services		**5.50**	**1.00**	**0.00**	**5.73**	**0.00**
ADMINISTRATIVE SUPPORT							
	ADMINISTRATION						
		Executive Staff	3			4.00	
		Admin. Support Staff	2			2.00	
		Clinical Director	0.5			1.00	
		Subtotal:	**5.5**	**0**	**0**	**7.00**	**0**
	FINANCIAL MANAGEMENT						
		Finance Staff				0.00	
		Subtotal:	**0**	**0**	**0**	**0.00**	**0**
	OFFICE SERVICES						
		Office Staff				4.30	
		Subtotal:	**0**	**0**	**0**	**4.30**	**0**
	CONTRACT HEALTH SERVICES						
		CHS Staff	3			2.00	
		CHS Manager				1.00	
		Utilization Review				0.40	
		Subtotal:	**3**	**0**	**0**	**3.40**	**0**
	BUSINESS OFFICE **						
		Business Manager	0.5			1.00	
		Patient Registration Tech.	3			2.22	
		Benefit Coordinator	1			2.06	
		Billing Clerk				2.91	
		Subtotal:	**4.5**	**0**	**0**	**8.19**	**0**
	SITE MANAGEMENT/RPMS/MIS						
		Computer Programmer/Analyst	1.25			2.73	
		Subtotal:	**1.25**	**0**	**0**	**2.73**	**0**
	QUALITY MANAGEMENT:						
		Performance Improvement Staff	1			1.71	
		Clerical Support				0.41	
		Subtotal:	**1**	**0**	**0**	**2.12**	**0**
	CENTRAL SUPPLY						
		Central Supply Staff				2.01	
		Medical Technician				0.00	
		Subtotal:	**0**	**0**	**0**	**2.01**	**0**
	INTERPRETERS						
		Interpreter				0.00	
		Subtotal:	**0**	**0**	**0**	**0.00**	**0**
	DRIVERS						
		Driver				1.38	
		Subtotal:	**0**	**0**	**0**	**1.38**	**0**
	RRM DEVIATIONS - ADMINISTRATION						
	**	Bus Office Secretary	1			0.00	
		Bus Office Switchboard	1			0.00	
		ADM_DEV3				0.00	
		ADM_DEV4				0.00	
		Subtotal:	**2**	**0**	**0**	**0.00**	**0**
	SUBTOTAL - Administration		**15.25**	**0.00**	**0.00**	**31.13**	**0.00**

	2004 Staffing	Needed for Current Use	Unfilled Positions / Vacancies	2015 Need From 2003 RRM	2015 Need Base on Use Projection
FACILITY SUPPORT					
HOUSEKEEPING					
Janitor/Housekeeper	3			10.21	
Subtotal:	**3**	**0**	**0**	**10.21**	**0**
FACILITY MAINTENANCE					
Maintenance Staff	2			8.22	
Subtotal:	**2**	**0**	**0**	**8.22**	**0**
CLINICAL ENGINEERING					
Clinical Engineering Staff				2.11	
Subtotal:	**0**	**0**	**0**	**2.11**	**0**
LAUNDRY					
Laundry Staff				1.11	
Subtotal:	**0**	**0**	**0**	**1.11**	**0**
FOOD SERVICES					
Food Services Staff	3			1.00	
Subtotal:	**3**	**0**	**0**	**1.00**	**0**
MATERIALS MANAGEMENT					
Warehouseman	1			2.05	
Subtotal:	**1**	**0**	**0**	**2.05**	**0**
STAFF HEALTH					
Registered Nurse				0.51	
Clerical Support				0.38	
Subtotal:	**0**	**0**	**0**	**0.89**	**0**
CLERICAL POOL					
Facility Support				0.83	
Subtotal:	**0**	**0**	**0**	**0.83**	**0**
SECURITY					
Security Personnel (housekeeping staff)				1.47	
Subtotal:	**0**	**0**	**0**	**1.47**	**0**
SUBTOTAL - Facility Support	**9.00**	**0.00**	**0.00**	**27.89**	**0.00**
EMERGENCY MEDICAL SERVICES					
EMS					
EMT-B				0.00	
EMT-I/P				0.00	
Clerks				0.00	
Supervisor				0.00	
SUBTOTAL - Emergency Medical Services	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
GRAND TOTAL	**108.45**	**12.00**	**1.00**	**167.03**	**0.00**

Appendix L: Provider Workload and Facility Need Projected to 2015

Appendix M: MSU Clinic Migration Data

Appendix M includes the following tables:

1. List of Communities Within Service Unit
2. Detailed chart of 2004 Patient Visits which shows the migratory pattern of how members of other tribes and Urban Indians use this Service Unit facilitiies and services. This data indicates the number of patient visits per tribe within each community receiving care at the Service Unit facilitieis.
3. Patient Visits by Albuquerque Area Tribe in FY 2004

COMMUNITIES WITHIN MSU
ALAMOGORDO
BENT
CARRIZOZO
CLOUDCROFT
EL PASO
LA LUZ
LINCOLN CO O
MESCALERO OS
MESCALERO RES
OTERO CO OTH
RUIDOSO
TULAROSA

MSU-Mescalero

FY 2004 Patient Visits

Community	Tribe	# of Patient Visits
ACOMA	NAVAJO TRIBE, AZ NM AND UT	11
	PUEBLO OF ACOMA, NM	14
ACOMA Total		**25**
ALAMO	NAVAJO TRIBE, AZ NM AND UT	2
ALAMO Total		**2**
ALAMOGORDO	ALEUT CORPORATION	2
	BAD RIVER BAND LAKE SUPERIOR, CHIPPEWA, WI	33
	CADDO TRIBE INDIAN, OK	7
	CHEROKEE NATION, OK	84
	CHICKASAW NATION, OK	49
	CHOCTAW NATION, OK	24
	CREEK NATION, OK	10
	JICARILLA APACHE TRIBE, NM	43
	MESCALERO APACHE TRIBE, NM	266
	MISSISSIPPI BAND CHOCTAW INDIANS, MS	10
	NAVAJO TRIBE, AZ NM AND UT	88
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	35
	OGLALA SIOUX TRIBE, SD	5
	ONEIDA TRIBE OF INDIANS, WI	38
	PUEBLO OF ACOMA, NM	14
	PUEBLO OF COCHITI, NM	1
	PUEBLO OF JEMEZ, NM	2
	PUEBLO OF LAGUNA, NM	9
	PUEBLO OF TAOS, NM	3
	PUEBLO OF ZIA, NM	3
	ROSEBUD SIOUX TRIBE, SD	2
	SAN CARLOS APACHE TRIBE, AZ	26
	SHOSHONE TRIBE WIND RIVER RES, WY	17
	SPIRIT LAKE SIOUX TRIBE, ND	3
	ST. REGIS BAND, MOHAWK INDIANS, NY	44
	YANKTON SIOUX TRIBE, SD	11
	YSLETA DEL-SUR PUEBLO, TX	3
	ZUNI TRIBE, NM	1
ALAMOGORDO Total		**833**
ALBUQUERQUE	KIOWA INDIAN TRIBE,OK	3
	MESCALERO APACHE TRIBE, NM	39
	NAVAJO TRIBE, AZ NM AND UT	12
	PUEBLO OF SAN FELIPE, NM	6
ALBUQUERQUE Total		**60**
ARIZONA UNK	MESCALERO APACHE TRIBE, NM	12
ARIZONA UNK Total		**12**
BENT	BAD RIVER BAND LAKE SUPERIOR, CHIPPEWA, WI	41
	COMANCHE INDIAN TRIBE, OK	2
	MESCALERO APACHE TRIBE, NM	18
	PUEBLO OF SAN FELIPE, NM	8
BENT Total		**69**
CANONCITO	NAVAJO TRIBE, AZ NM AND UT	18
CANONCITO Total		**18**
CARLSBAD	CHICKASAW NATION, OK	4
	CHOCTAW NATION, OK	23
	CREEK NATION, OK	15
CARLSBAD Total		**42**
CARRIZOZO	CHEYENNE-ARAPAHO TRIBES, OK	2
	COMANCHE INDIAN TRIBE, OK	3
	JICARILLA APACHE TRIBE, NM	16
	KIOWA INDIAN TRIBE,OK	9
	MESCALERO APACHE TRIBE, NM	1238
	NAVAJO TRIBE, AZ NM AND UT	30
	NEZ PERCE TRIBE, ID	2
	PUEBLO OF COCHITI, NM	1
	PUEBLO OF TAOS, NM	4
	All Other (tribes with <50 visits at any facility in 2004)	18
CARRIZOZO Total		**1323**

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Community	Tribe	# of Patient Visits
CHAVES CO OT	CHEROKEE NATION, OK	56
	CHOCTAW NATION, OK	2
	COOK INLET REGION, INC.	2
	JICARILLA APACHE TRIBE, NM	21
	SAC AND FOX TRIBE, OK	7
	All Other (tribes with <50 visits at any facility in 2004)	17
CHAVES CO OT Total		105
CLOUDCROFT	CHEROKEE NATION, OK	1
	MESCALERO APACHE TRIBE, NM	54
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	2
CLOUDCROFT Total		57
CLOVIS	COVELO INDIAN COMM ROUND VALLEY RES, CA	8
	NAVAJO TRIBE, AZ NM AND UT	4
CLOVIS Total		12
COCHITI	PUEBLO OF COCHITI, NM	3
COCHITI Total		3
COUNSELLORS	NAVAJO TRIBE, AZ NM AND UT	1
COUNSELLORS Total		1
CROWNPOINT	NAVAJO TRIBE, AZ NM AND UT	4
CROWNPOINT Total		4
CUBA	NAVAJO TRIBE, AZ NM AND UT	2
CUBA Total		2
DONNA ANA CO	CHEROKEE NATION, OK	31
	CREEK NATION, OK	13
	KIOWA INDIAN TRIBE,OK	1
	MESCALERO APACHE TRIBE, NM	7
	PUEBLO OF SANTA CLARA, NM	11
	WHITE MOUNTAIN APACHE TRB, AZ	2
	YSLETA DEL-SUR PUEBLO, TX	3
DONNA ANA CO Total		68
DULCE	JICARILLA APACHE TRIBE, NM	3
	All Other (tribes with <50 visits at any facility in 2004)	1
DULCE Total		4
DURANGO	CONFEDERATED TRIBES,COLVILLE RES, WA	1
DURANGO Total		1
EDDY CO. OTH	CHEROKEE NATION, OK	2
	CHEYENNE RIVER SIOUX TRIBE, SD	5
	CHICKASAW NATION, OK	1
	CHOCTAW NATION, OK	28
	CREEK NATION, OK	12
	CROW TRIBE, MT	5
	MESCALERO APACHE TRIBE, NM	13
	NAVAJO TRIBE, AZ NM AND UT	1
	OGLALA SIOUX TRIBE, SD	1
	PASCUA YAQUI TRIBE, AZ	1
	ROSEBUD SIOUX TRIBE, SD	1
	All Other (tribes with <50 visits at any facility in 2004)	1
EDDY CO. OTH Total		71
EL PASO	CHEROKEE NATION, OK	4
	CHOCTAW NATION, OK	11
	FORT SILL APACHE TRIBE, OK	23
	KIOWA INDIAN TRIBE,OK	2
	MESCALERO APACHE TRIBE, NM	5
	NAVAJO TRIBE, AZ NM AND UT	11
	NEZ PERCE TRIBE, ID	10
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	2
	PRAIRIE BAND POTAWATOMI, KS	17
	PUEBLO OF ACOMA, NM	1
	PUEBLO OF SAN FELIPE, NM	1
	YSLETA DEL-SUR PUEBLO, TX	77
	All Other (tribes with <50 visits at any facility in 2004)	10
EL PASO Total		174

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Community	Tribe	# of Patient Visits
FARMINGTON	JICARILLA APACHE TRIBE, NM	2
	NAVAJO TRIBE, AZ NM AND UT	11
FARMINGTON Total		13
FT.DEFIANCE	NAVAJO TRIBE, AZ NM AND UT	7
FT.DEFIANCE Total		7
GALLUP	NAVAJO TRIBE, AZ NM AND UT	2
GALLUP Total		2
IGNACIO	UTE MOUNTAIN TRB, CO NM AND UT	3
IGNACIO Total		3
ISLETA PUEBL	PUEBLO OF ISLETA, NM	4
ISLETA PUEBL Total		4
JEMEZ PUEBLO	PUEBLO OF JEMEZ, NM	1
	SAN CARLOS APACHE TRIBE, AZ	1
JEMEZ PUEBLO Total		2
LA LUZ	CHEROKEE NATION, OK	4
	MESCALERO APACHE TRIBE, NM	90
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	2
	PYRAMID LAKE PAIUTE TRIBE, NV	6
LA LUZ Total		102
LAS CRUCES	CHEROKEE NATION, OK	26
	CHEYENNE RIVER SIOUX TRIBE, SD	2
	CHOCTAW NATION, OK	13
	FORT SILL APACHE TRIBE, OK	4
	JICARILLA APACHE TRIBE, NM	2
	MESCALERO APACHE TRIBE, NM	23
	NAVAJO TRIBE, AZ NM AND UT	32
	PUEBLO OF LAGUNA, NM	4
	PUEBLO OF TAOS, NM	1
	SALT RIVER PIMA-MARICOPA IND COMM, AZ	3
	YSLETA DEL-SUR PUEBLO, TX	8
LAS CRUCES Total		118
LEA CO. OTH	CHEROKEE NATION, OK	13
	CHEYENNE RIVER SIOUX TRIBE, SD	3
	YUROK TRIBE HOOPA VALLEY RES, CA	23
LEA CO. OTH Total		39
LINCOLN CO O	CHEROKEE NATION, OK	2
	CHICKASAW NATION, OK	32
	CHOCTAW NATION, OK	2
	JICARILLA APACHE TRIBE, NM	3
	MESCALERO APACHE TRIBE, NM	185
	MISSISSIPPI BAND CHOCTAW INDIANS, MS	4
	NAVAJO TRIBE, AZ NM AND UT	62
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	5
	NORTHERN CHEYENNE TRIBE, MT	2
	ONEIDA TRIBE OF INDIANS, WI	21
	SEMINOLE NATION, OK	9
LINCOLN CO O Total		327
MAGDALENA	NAVAJO TRIBE, AZ NM AND UT	1
MAGDALENA Total		1
MESCALERO OS	MESCALERO APACHE TRIBE, NM	501
	NAVAJO TRIBE, AZ NM AND UT	11
	PUEBLO OF ACOMA, NM	1
	PUEBLO OF LAGUNA, NM	4
	ZUNI TRIBE, NM	1
	All Other (tribes with <50 visits at any facility in 2004)	7
MESCALERO OS Total		525

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Community	Tribe	# of Patient Visits
MESCALRO RES	ARAPAHO TRIBE,WIND RIVER RES, WY	7
	ARIKARA,THREE AFFIL TRBS FT BERTHOLD RS,ND	2
	ASSINIBOINE/SIOUX TRBS,FT PECK, MT-ASSINIB	56
	ASSINIBOINE/SIOUX TRBS,FT PECK, MT-SIOUX	4
	CHEROKEE NATION, OK	12
	CHEYENNE RIVER SIOUX TRIBE, SD	3
	CHEYENNE-ARAPAHO TRIBES, OK	61
	CHIPPEWA-CREE INDIANS,ROCKY BOY RES, MT	7
	CHOCTAW NATION, OK	86
	COMANCHE INDIAN TRIBE, OK	65
	CREEK NATION, OK	9
	CROW TRIBE, MT	5
	FORT BELKNAP IND COMM, GROS VENTRE, MT	8
	FORT SILL APACHE TRIBE, OK	15
	FT. MCDOWELL MOHAVE-APACHE IND COMM, AZ	35
	GILA RIVER PIMA MARICOPA INDIAN COMM, AZ	11
	HOPI TRIBE, AZ	32
	JICARILLA APACHE TRIBE, NM	45
	KICKAPOO TRIBE, KS	60
	KIOWA INDIAN TRIBE,OK	27
	MANDAN,THREE AFFIL TRBS, FT BERTHOLD RS,ND	10
	MENOMINEE IND TRIBE, WI	43
	MESCALERO APACHE TRIBE, NM	24757
	NAVAJO TRIBE, AZ NM AND UT	670
	NEZ PERCE TRIBE, ID	4
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	24
	NORTHERN CHEYENNE TRIBE, MT	43
	OGLALA SIOUX TRIBE, SD	39
	OTOE-MISSOURIA TRIBE, OK	41
	PUEBLO OF ACOMA, NM	4
	PUEBLO OF COCHITI, NM	7
	PUEBLO OF ISLETA, NM	42
	PUEBLO OF LAGUNA, NM	71
	PUEBLO OF PICURIS, NM	13
	PUEBLO OF SAN FELIPE, NM	31
	PUEBLO OF SAN ILDEFONSO, NM	8
	PUEBLO OF SAN JUAN, NM	15
	PUEBLO OF SANTA CLARA, NM	12
	PUEBLO OF SANTO DOMINGO, NM	54
	PUEBLO OF ZIA, NM	11
	QUAPAW TRIBE, OK	68
	QUECHAN TRIBE, CA	31
	SALT RIVER PIMA-MARICOPA IND COMM, AZ	15
	SAN CARLOS APACHE TRIBE, AZ	204
	SEMINOLE NATION, OK	5
	SHOSHONE-BANNOCK TRIBES FORT HALL RES, ID	14
	SOUTHERN UTE TRIBE, CO	7
	TLINGIT & HAIDA INDIANS OF ALASKA	53
	TOHONO O'ODHAM NATION,AZ (FORMERLY PAPAGO)	13
	UTE INDIAN TRIBE, UINTAH AND OURAY RES, UT	19
	UTE MOUNTAIN TRB, CO NM AND UT	67
	WHITE MOUNTAIN APACHE TRB, AZ	61
	YANKTON SIOUX TRIBE, SD	10
	ZUNI TRIBE, NM	26
	All Other (tribes with <50 visits at any facility in 2004)	66
MESCALRO RES Total		27108
MESITA	MESCALERO APACHE TRIBE, NM	5
	PUEBLO OF LAGUNA, NM	2
MESITA Total		7
MILAN	NAVAJO TRIBE, AZ NM AND UT	1
MILAN Total		1
NAMBE	PUEBLO OF NAMBE, NM	3
NAMBE Total		3

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Community	Tribe	# of Patient Visits
NEW MEXICO UNK	CHEROKEE NATION, OK	1
	CROW TRIBE, MT	2
	MESCALERO APACHE TRIBE, NM	4
	All Other (tribes with <50 visits at any facility in 2004)	1
NEW MEXICO UNK Total		8
OTERO CO OTH	BAD RIVER BAND LAKE SUPERIOR, CHIPPEWA, WI	9
	CHICKASAW NATION, OK	12
	MESCALERO APACHE TRIBE, NM	50
	NAVAJO TRIBE, AZ NM AND UT	2
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	2
OTERO CO OTH Total		75
PAGUATE	PUEBLO OF TAOS, NM	1
PAGUATE Total		1
PINEHILL	NAVAJO TRIBE, AZ NM AND UT	1
PINEHILL Total		1
RAMAH RESERV	NAVAJO TRIBE, AZ NM AND UT	6
RAMAH RESERV Total		6
RIO RANCHO	CHICKASAW NATION, OK	3
RIO RANCHO Total		3
ROSEWELL	CHEROKEE NATION, OK	27
	CHOCTAW NATION, OK	28
	CREEK NATION, OK	17
	DOYAN, LIMITED	1
	JICARILLA APACHE TRIBE, NM	3
	MESCALERO APACHE TRIBE, NM	15
	NAVAJO TRIBE, AZ NM AND UT	12
	PUEBLO OF LAGUNA, NM	11
	PUEBLO OF SAN JUAN, NM	6
	SAC AND FOX TRIBE, OK	1
	SPOKANE TRIBE, WA	6
	TURTLE MOUNTAIN BAND CHIPPEWA, ND	1
	All Other (tribes with <50 visits at any facility in 2004)	1
ROSEWELL Total		129
RUIDOSO	BLACKFEET TRIBE, MT	2
	CHEROKEE NATION, OK	60
	CHEYENNE-ARAPAHO TRIBES, OK	4
	CHICKASAW NATION, OK	4
	CHOCTAW NATION, OK	143
	COOK INLET REGION, INC.	1
	CREEK NATION, OK	2
	KIOWA INDIAN TRIBE,OK	12
	MESCALERO APACHE TRIBE, NM	200
	MINNESOTA CHIPPEWA, WHITE EARTH BAND, MN	16
	NAVAJO TRIBE, AZ NM AND UT	270
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	11
	OGLALA SIOUX TRIBE, SD	23
	OSAGE TRIBE, OK	31
	OTOE-MISSOURIA TRIBE, OK	14
	PUEBLO OF JEMEZ, NM	10
	PUEBLO OF LAGUNA, NM	3
	QUAPAW TRIBE, OK	12
	ROSEBUD SIOUX TRIBE, SD	7
	SAN CARLOS APACHE TRIBE, AZ	15
	SANTEE SIOUX NATION, NE	10
	WHITE MOUNTAIN APACHE TRB, AZ	7
	YSLETA DEL-SUR PUEBLO, TX	28
	ZUNI TRIBE, NM	16
	All Other (tribes with <50 visits at any facility in 2004)	44
RUIDOSO Total		945
SAN FELIPE	PUEBLO OF SAN FELIPE, NM	6
SAN FELIPE Total		6
SAN JUAN	NAVAJO TRIBE, AZ NM AND UT	2
	PUEBLO OF SAN JUAN, NM	3
SAN JUAN Total		5

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Community	Tribe	# of Patient Visits
SAN MIGUEL	CHEROKEE NATION, OK	1
SAN MIGUEL Total		1
SANT DOMINGO	PUEBLO OF SANTO DOMINGO, NM	2
SANT DOMINGO Total		2
SANTA CLARA	PUEBLO OF SANTA CLARA, NM	7
SANTA CLARA Total		7
SANTA FE	MESCALERO APACHE TRIBE, NM	2
	PUEBLO OF SAN ILDEFONSO, NM	3
SANTA FE Total		5
SHIPROCK	NAVAJO TRIBE, AZ NM AND UT	7
SHIPROCK Total		7
SOCORRO	MESCALERO APACHE TRIBE, NM	3
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	1
SOCORRO Total		4
TAOS	PUEBLO OF TAOS, NM	2
TAOS Total		2
TAOS CO OTH	PUEBLO OF TAOS, NM	19
TAOS CO OTH Total		19
TAOS PUEBLO	PUEBLO OF TAOS, NM	5
TAOS PUEBLO Total		5
TEXAS UNK	CHEROKEE NATION, OK	37
	CHOCTAW NATION, OK	62
	KARUK TRIBE, CA	17
	MESCALERO APACHE TRIBE, NM	12
	PRAIRIE BAND POTAWATOMI, KS	9
	TURTLE MOUNTAIN BAND CHIPPEWA, ND	3
TEXAS UNK Total		140
THREE RIVERS	MESCALERO APACHE TRIBE, NM	76
	NAVAJO TRIBE, AZ NM AND UT	3
THREE RIVERS Total		79
TORREON	NAVAJO TRIBE, AZ NM AND UT	1
TORREON Total		1
TULAROSA	BAD RIVER BAND LAKE SUPERIOR, CHIPPEWA, WI	1
	CADDO TRIBE INDIAN, OK	6
	CHEROKEE NATION, OK	56
	CHEYENNE-ARAPAHO TRIBES, OK	13
	CHICKASAW NATION, OK	17
	CHOCTAW NATION, OK	15
	COMANCHE INDIAN TRIBE, OK	30
	CONFED TRIBES AND BANDS, YAKAMA NATION, WA	2
	EASTERN BAND OF CHEROKEE IND, NC	3
	INUPIAT COMMUNITY OF THE ARTIC SLOPE	21
	JICARILLA APACHE TRIBE, NM	15
	KIOWA INDIAN TRIBE,OK	26
	KLAMATH INDIAN TRIBE, OR	3
	MESCALERO APACHE TRIBE, NM	529
	MINNESOTA CHIPPEWA, WHITE EARTH BAND, MN	11
	NAVAJO TRIBE, AZ NM AND UT	30
	NON-INDIAN (AND NON-FED RECOGNIZED INDIAN)	8
	OTOE-MISSOURIA TRIBE, OK	15
	PAIUTE-SHOSHONE IND BISHOP COMM, CA	30
	PUEBLO OF ACOMA, NM	25
	PUEBLO OF TAOS, NM	10
	PYRAMID LAKE PAIUTE TRIBE, NV	41
	ROSEBUD SIOUX TRIBE, SD	2
	SAN CARLOS APACHE TRIBE, AZ	9
	TLINGIT & HAIDA INDIANS OF ALASKA	52
	All Other (tribes with <50 visits at any facility in 2004)	1
TULAROSA Total		971
UNKNOWN	CHOCTAW NATION, OK	2
UNKNOWN Total		2
ZUNI PUEBLO	ZUNI TRIBE, NM	7
ZUNI PUEBLO Total		7
All Other (communities with <50 visits at any facility in 2004)		252
Total		33831

MSU
2004 Patient Visits by Albuquerque Area Tribe

The following chart indicates the facilities where tribal members of this Service Unit have counted as Active Users in the past three years.

FISCAL YEAR 2004

TRIBE	FACILITY NAME	Total
MESCALERO APACHE TRIBE, NM	MESCALERO HO	28,208
	ALBUQUERQUE HOSPITAL	579
	SANTA FE HOSPITAL	255
	UTE MOUNTAIN UTE HEALTH CENTER	187
	ACL HOSPITAL	142
	CANONCITO HS	82
	ALBUQUERQUE INDIAN DENTAL CLINIC	72
	DULCE HEALTH CENTER	62
	ISLETA HEALTH CENTER	55
	SANTA CLARA HC	46
	ZUNI HO	40
	ALAMO HL CENTER	36
	SANDIA H.STA	33
	COCHITI H.ST	19
	SOUTHERN UTE HEALTH CENTER	17
	TAOS-PICURIS HEALTH CENTER	14
	PINE HILL HC	11
	JEMEZ HEALTH CENTER	6
	SAN FELIPE HS	6
	LAGUNA H CT	4
MESCALERO APACHE TRIBE, NM Total		29,874

Appendix N: Contract Health Services

MSU "Blanket" Expenditures for Contracted Services

At time of printing, there was insufficient data or data was inaccessible to CL Associates for this Appendix.

Appendix O: Top 10 Out-Patient Diagnoses FY 2000-2003

The following charts list the diagnoses, the number of cases, and the amounts billed / received for cases utilizing CHS funds within the Service Unit tribes.

FISCAL YEAR 2000

Diagnosis Description	Billed	Allowed	Alt. Resource	Paid	# of Claims
PNEUMONIA, ORGANISM NOS	$ 372,338.38	$ 267,761.22	$ 11.70	$ 267,749.52	8
CHRONIC RENAL FAILURE	219,376.20	216,373.21	73,447.26	142,925.95	51
RESPIRATORY FAILURE	90,336.15	90,332.75	-	90,332.75	1
ACUTE PANCREATITIS	555,752.24	219,393.14	183,631.20	35,761.94	8
DUODENUM INJURY-OPEN	33,766.10	33,759.90	-	33,759.90	1
CHEST PAIN NOS	36,560.61	31,525.12	-	31,525.12	8
CHOLELITH / AC CHOLECYST	52,296.65	30,441.05	-	30,441.05	7
LUNG INJURY NOS-OPEN	22,877.10	22,877.10	-	22,877.10	1
LIVER LACERATION, MINOR	29,252.21	22,249.80	-	22,249.80	1
CHOLELITH W OTH CHOLECYS	38,158.80	24,173.76	9,126.04	15,047.72	5
	$ 1,450,714.44	**$ 958,887.05**	**$ 266,216.20**	**$ 692,670.85**	**91**

FISCAL YEAR 2001

Diagnosis Description	Billed	Allowed	Alt. Resource	Paid	# of Claims
CHRONIC RENAL FAILURE	$ 183,527.47	$ 185,233.94	$ 61,108.24	$ 124,125.70	41
DM W COMA TYPE II UNCNTR	120,749.45	120,749.45	-	120,749.45	1
LATRL AMI NEC-INIT EPISD	60,162.25	59,420.00	-	59,420.00	2
VENOUS THROMBOSIS NEC	47,637.68	47,505.51	-	47,505.51	2
MALLORY-WEISS SYNDROME	30,175.42	26,602.50	-	26,602.50	3
FOOD/VOMIT PNEUMONITIS	27,672.16	23,510.25	-	23,510.25	2
POIS-AROM ANALGESICS NEC	32,254.29	22,200.68	-	22,200.68	2
CHOLELITH W OTH CHOLECYS	34,260.00	20,563.38	-	20,563.38	7
ACUTE RENAL FAILURE NOS	20,210.24	20,390.00	-	20,390.00	1
Intestinal Obstruct Nos	15,078.00	18,550.00	-	18,550.00	1
	$ 571,726.96	**$ 544,725.71**	**$ 61,108.24**	**$ 483,617.47**	**62**

FISCAL YEAR 2002

Diagnosis Description	Billed	Allowed	Alt. Resource	Paid	# of Claims
REHABILITATION PROC NEC	$ 68,277.81	$ 68,277.81	$ -	$ 68,277.81	2
FX DORSAL VERTEBRA-CLOSE	64,817.60	40,335.17	-	40,335.17	3
FRACTURE ACETABULUM-CLOS	73,875.13	34,519.01	-	34,519.01	2
BIPOL AFF, MIXED-UNSPEC	25,272.75	25,272.75	-	25,272.75	1
CHOLELITH / AC CHOLECYST	32,177.79	23,081.36	-	23,081.36	5
CHOLELITH W OTH CHOLECYS	37,348.91	25,193.59	2,472.07	22,721.52	6
AC ALCOHOLIC HEPATITIS	30,792.85	29,305.72	7,045.43	22,260.29	3
SINGLE LB/BY C-SECTION	16,581.00	20,405.00	-	20,405.00	1
FX MID/PRX PHAL, HAND-OP	19,887.49	19,887.49	-	19,887.49	1
ALCOHOL CIRRHOSIS LIVER	33,082.25	29,633.44	10,537.28	19,096.16	3
	$ 402,113.58	**$ 315,911.34**	**$ 20,054.78**	**$ 295,856.56**	**27**

FISCAL YEAR 2003

Diagnosis Description	Billed	Allowed	Alt. Resource	Paid	# of Claims
RECUR MJR DEPRESS-SEVERE	$ 49,435.61	$ 49,435.61	$ -	$ 49,435.61	2
CORNARY ATHERO-NATV VESL	47,477.46	47,477.46	-	47,477.46	1
ALCOH DEP NEC/NOS-CONTIN	46,724.79	46,724.79	-	46,724.79	3
ACUTE PANCREATITIS	40,885.61	33,938.83	-	33,938.83	4
PORTAL HYPERTENSION	94,654.88	32,255.97	-	32,255.97	4
PNEUMONIA, ORGANISM NOS	99,795.69	54,262.24	24,173.99	30,088.25	16
CHOLELITH W OTH CHOLECYS	39,179.85	23,383.93	-	23,383.93	6
ACUTE CHOLECYSTITIS	18,581.37	20,966.42	-	20,966.42	2
CALC GB & BDUCT W/OBSTR	58,672.70	20,450.90	-	20,450.90	2
MAJOR DEPRESS DIS-SEVERE	20,045.82	20,045.82	-	20,045.82	1
	$ 515,453.78	**$ 348,941.97**	**$ 24,173.99**	**$ 324,767.98**	**41**

Appendix P: Essential Elements of RRM For MIH (2015)

RRM2004_112142004

Last Update: 11/24/04

Today's Date: 9/16/05 7:04 PM

RRM FACILITY IDENTIFICATION INFORMATION

(USER INPUT ARE IN YELLOW CELLS, BLUE CELLS WILL OVERRIDE FORMULAS)

1.	HSP Project Name:			
2.	Facility Name:		MESCALERO HOSPITAL(2015MP)	
3.	Contact:			
	Telephone No:			
4.	Area - Name		ALBUQUERQU	
5.	Service Unit - Name		MESCALERO	
	- Code			
6.	Facility - Code			
	Type of Facility		Hospital	
FACILITY SPACE ESTIMATES			Metric (m^2):	
	Calculated Space Estimate:		4,318	m^2
7.	In-Patient Treatment Space:		493	m^2
8.	Ambulatory Treatment Space:		6,337	m^2
9.	Other:			m^2
10.	Other:		-	m^2
11.	HSP Build Area less Amb and Inp			m^2
	Space Total:		6,830	m^2
12.	Number of Quarters:			
13.	Quarters Space:		-	m^2
	TOTAL SQUARE METERS:		**6,830**	**m^2**
14.	Parking Spaces		-	spaces
GROUNDS ESTIMATES				
	Calculated Area:		4	ha
15.	Area of Grounds (Override):			ha
POPULATION				
16.	Inpatient		**5,147**	
17.	Ambulatory		**5,147**	
18.	Eye Care		**5,147**	
19.	Audiology		**5,147**	
20.	Dental		**5,147**	
21.	Social Services		**5,147**	
22.	Mental Health		**5,147**	
23.	Nutrition		**5,147**	
24.	Public Health Nursing	Census Here	5147	**5,147**
25.	Emergency Medical Service		**5,147**	
26.	Health Education		**5,147**	
OTHER FACTORS				
27.	EMS Program?		NO	
28.	% Total Runs Purchased			
29.	Sq. Kilometers Served			
30.	Driving time 100km or over 90 min to nearest ER?			Yes
31.	Driving time 64km or over 60 min to nearest ER?			Yes
32	Patron Rations?		YES	
33.	24-Hour Security?		NO	
			TOTAL RRM STAFFING:	**166.00**

TOTAL RRM STAFFING:

166.00

There are overrides in the EMS worksheet that can be used to overide the calculated workloads. There is also some additional cost information available in the EMS worksheet.

	A	B	C	D	E	F	G	H	I	Q	IV
1			RRM STAFFING NEEDS SUMMARY								
2				Last Update:		11/24/04					
3		Program:		MESCALERO HOSPITAL(2015MP)							
4				Today's Date:		9/16/05 7:07 PM					
6		RRM Category	Staffing Category			FTEs		Staff Rounded by Discipline/Department			
8		INPATIENT CARE						Discipline	Department		
9			11.00	**Acute Care Nursing**							
10			**INPATIENT PHYSICIANS**								
11				Chief of Service		0.08					
12				GM Physician		0.53					
13				Peds. Physician		0.00					
14				OB/GYN Physician		0.00					
15				Clerical Support		0.13					
16			**SURGEONS**			**0.74**		1			
17				General Surgeon		0.00					
18				OB/GYN Surgeon		0.00					
19				Nurse/Midwife		0.00					
20				Anethesiologist		0.00					
21			**NURSING**			**0.00**		0.0			
22				Nursing Administration		0.00					
23				Admin. Clerical Support		0.00					
24				GM/SURG-Registered Nurse		0.00					
25				GM/SURG-LPN/Technician		0.00					
26				GM/SURG-Clerical Support		0.00					
27				PED-Registered Nurse		0.00					
28				PED-LPN/Technician		0.00					
29				PED-Clerical Support		0.00					
30				OB/L&D-Registered Nurse		0.00					
31				OB/L&D, LPN/Technician		0.00					
32				OB/L&D- Clerical Support		0.00					
33				Newborn-LPN/Technician		0.00					
34				Newborn-Clerical Support		0.00					
35				Nursery, RN, Fixed		0.00					
36				Nursery LPN/Technician		0.00					
37				Nursery, Clerical Support		0.00					
38				ICU, RN		0.00					
39				ICU, Clerical Support		0.00					
40				Step-Down Unit, RN,		0.00					
41				Step-Down Unit, LPN		0.00					
42				Step-Down Unit, Clerical Support		0.00					
43				OR RN		0.00					
44				OR, LPN/Technician		0.00					
45				Post Anesthesia Recovery, RN		0.00					
46				Ambulatory Surgery, RN		0.00					
47				Psych-RN, Fixed		0.00					
48				Psych, LPN Technican		0.00					
49				Psych, Clerical Support		0.00					
50				Quality Improvement Nurse		0.00					
51				Discharge Planning Nurse		0.00					
52				Observ. Bed-Registered Nurse		0.00					
53				Patient Escort, RN		0.00					
54				Nurse Educator		0.00					
55				SUBTOTAL:		**0.00**		0.0			

	A	B	C	D	E	F	G	H	I	Q	IV
1			RRM STAFFING NEEDS SUMMARY								
2				Last Update:		11/24/04					
3		Program:		MESCALERO HOSPITAL(2015MP)							
4				Today's Date:		9/16/05 7:07 PM					
6		RRM Category	Staffing Category			FTEs		Staff Rounded by Discipline/Department			
56			INPATIENT DEVIATION(S)								
57				INP_DEV1		0.00					
58				INP_DEV2		0.00					
59				INP_DEV3		0.00					
60				INP_DEV4		0.00					
61				INP_DEV5		0.00					
62				INP_DEV6		0.00					
63				INP_DEV7		0.00					
64				INP_DEV8		0.00					
65				INP_DEV9		0.00					
66				SUBTOTAL:		**0.00**		0.0			
67			**Subtotal Inpatient Services**			**0.74**			**1.0**		
68		AMBULATORY CARE									
69			EMERGENCY								
70				ER/After Hours Staff		1.86					
71				ER RN Supervisor		0.00					
72				ER Medical Clerks		0.00					
73				RNs, ER		0.00					
74				SUBTOTAL:		1.86		2.0			
75			AMBULATORY PHYSICIAN								
76				Primary Care Provider		6.92					
77				Specialty Care Provider		0.18					
78				Primary Care Provider (CHA/P)		0.00					
79				EMS Medical Director		0.00					
80				Clerical Support		1.62					
81				SUBTOTAL:		8.72		9.0			
82			AMBULATORY SURGERY								
83				General Surgeon		0.00					
84				SUBTOTAL:		0.00		0.0			
85			NURSING AMBULATORY								
86				Nurse Supervisor. (in Hosp. OPD)		1.00					
87				Medical Clerk, Exec. Support, Hosp (		1.00					
88				Nurse Manager		2.09					
89				Registered Nurse, Core Activities		8.74					
90				LPN		2.91					
91				Clerical Support		2.74					
92				RNs, Patient Escort		0.00					
93				RNs, Ambulatory Clinic Observation		0.00					
94				SUBTOTAL:		18.48		18.0			
95			EYE CARE								
96				Optometrist		1.10					
97				Optometric Assistant		1.07					
98				Optometric Technician		1.07					
99				Ophthalmologist		0.00					
100				Ophthalmologist Assistant		0.00					
101				SUBTOTAL:		3.25		3.0			

	A	B	C	D	E	F	G	H	I	Q	IV
1			RRM STAFFING NEEDS SUMMARY								
2				Last Update:		11/24/04					
3		Program:		MESCALERO HOSPITAL(2015MP)							
4				Today's Date:		9/16/05 7:07 PM					
6		RRM Category	Staffing Category			FTEs		Staff Rounded by Discipline/Department			
102			AUDIOLOGY								
103				Audiologist		0.00					
104				Audiometric Technician		0.00					
105				SUBTOTAL:		0.00		0.0			
106			PHYSICAL THERAPY								
107				Physical Therapist		0.89					
108				SUBTOTAL:		0.89		1.0			
109			CLERICAL POOL								
110				PT, Audiology & Eye Care		0.83		1.0			
111			DENTAL								
112				Dentist		6.22					
113				Dental Assistant		12.44					
114				Dental Hygienist		1.55					
115				Clerical Support		1.87					
116				SUBTOTAL:		22.08		22.0			
117		AMBULATORY DEVIATIONS									
118				Ambulatory Deviation 1		0.00					
119				Ambulatory Deviation 2		0.00					
120				Ambulatory Deviation 3		0.00					
121				Ambulatory Deviation 4		0.00					
122				Ambulatory Deviation 5		0.00					
123				Ambulatory Deviation 6		0.00					
124				SUBTOTAL:		0.00		0.0			
125			Subtotal Ambulatory Clinics			56.11			56.0		
126		CLINICAL SUPPORT (ANCILLARY SERVICES)									
127			LABORATORY								
128				Medical Technologist		2.76					
129				Medical Technician (CHA/P)		0.00					
130				Medical Technician		2.01					
131				SUBTOTAL:		4.78		5.0			
132			PHARMACY								
133				Pharmacist		6.68					
134				Pharmacist (CHA/P)		0.00					
135				Pharmacy Technician		2.28					
136				SUBTOTAL:		8.96		9.0			
137			DIAGNOSTIC IMAGING								
138				Imaging Technologist		2.37					
139				Imaging Technologist (CHA/P)		0.00					
140				SUBTOTAL:		2.37		2.0			

	A	B	C	D	E	F	G	H	I	Q	IV
1			RRM STAFFING NEEDS SUMMARY								
2				Last Update:		11/24/04					
3		Program:		MESCALERO HOSPITAL(2015MP)							
4				Today's Date:		9/16/05 7:07 PM					
6		RRM Category	Staffing Category			FTEs		Staff Rounded by Discipline/Department			
141			MEDICAL RECORDS								
142				Medical Records Administrator		1.00					
143				Medical Records Technician		7.29					
144				Medical Records Technician (CHA/P)		0.00					
145				PCC Supervisor		0.81					
146				PCC Data Entry Personnel		3.24					
147				PCC Data Entry Personnel (CHA/P)		0.00					
148				Coder		4.09					
149				Medical Runner		0.36					
150				SUBTOTAL:		**16.78**		17.0			
151			RESPIRATORY THERAPY								
152				Respiratory Staff		0.00					
153				SUBTOTAL:		**0.00**		0.0			
154			CLERICAL POOL								
155				Lab, Pharm, & Imaging		**0.83**		1.0			
156			RRM DEVIATIONS - ANCILLARY								
157				ANCIL_DEV1		0.00					
158				ANCIL_DEV2		0.00					
159				ANCIL_DEV3		0.00					
160				ANCIL_DEV4		0.00					
161				SUBTOTAL:		0.00		0.0			
162			**Subtotal Ancillary Services**			**33.72**			**34.0**		
163		COMMUNITY HEALTH									
164			PUBLIC HEALTH NUTRITION								
165				Nutritionist		**1.84**		2.0			
166			PUBLIC HEALTH NURSING								
167				Public Health Nurse Manager		1.00					
168				Public Health Nurse		6.51					
169				Public Health Nurse - School		0.00					
170				Clerical Support		0.82					
171						**8.33**		8.0			
172			HEALTH EDUCATION								
173				Public Health Educator		**1.29**		1.0			
174			OFFICE OF ENVIRONMENTAL HEALTH & ENGINEERING								
175				OEHE RRM		**1.00**		1.0			
176		BEHAVIORAL HEALTH SERVICES									
177			MENTAL HEALTH								
178				Mental Health Staff		**2.97**		3.0			
179			SOCIAL SERVICES								
180				MSW Counselor Inpatient Only		0.09					
181				Social Service Staff		1.84					
182				SUBTOTAL:		**1.93**		2.0			
183			CLERICAL POOL								
184				Behavioral Health		**0.83**		1.0			

	A	B	C	D	E	F	G	H	I	Q	IV
1			RRM STAFFING NEEDS SUMMARY								
2				Last Update:		11/24/04					
3		Program:		MESCALERO HOSPITAL(2015MP)							
4				Today's Date:		9/16/05 7:07 PM					
6		RRM Category	Staffing Category			FTEs		Staff Rounded by Discipline/Department			
185			RRM DEVIATIONS - COMMUNITY HEALTH								
186				CM_DEV1		0.00					
187				CM_DEV2		0.00					
188				CM_DEV3		0.00					
189				CM_DEV4		0.00					
190				CM_DEV5		0.00					
191				CM_DEV6		0.00					
192				CM_DEV7		0.00					
193				CM_DEV8		0.00					
194				CM_DEV9		0.00					
195				CM_DEV10		0.00					
196				CM_DEV11		0.00					
197				CM_DEV12		0.00					
198				SUBTOTAL:		**0.00**		0.0			
199			**Subtotal Community Health Services**			**18.20**			**18.0**		
200		ADMINISTRATIVE SUPPORT									
201			**ADMINISTRATION**								
202				Executive Staff		4.00					
203				Admin. Support Staff		2.00					
204				Clinical Director		1.00					
205				SUBTOTAL:		**7.00**		7.0			
206			**FINANCIAL MANAGEMENT**								
207				Finance Staff		0.00		0.0			
208			**OFFICE SERVICES**								
209				Office Staff		4.30		4.0			
210			**CONTRACT HEALTH SERVICES**								
211				CHS Staff		2.00					
212				CHS Manager		1.00					
213				Utilization Review		0.40					
214				SUBTOTAL:		**3.40**		3.0			
215			**BUSINESS OFFICE**								
216				Business Manager		1.00					
217				Patient Registration Tech.		2.22					
218				Benefit Coordinator		2.06					
219				Billing Clerk		2.91					
220				SUBTOTAL:		8.19		8.0			
221			**SITE MANAGEMENT/RPMS/MIS**								
222				Computer Programer/Analyst		2.73					
223											
224				SUBTOTAL:		2.73		3.0			
225			**QUALITY MANAGEMENT**								
226				Performance Improvement Staff		1.71					
227				Clerical Support		0.41					
228				SUBTOTAL:		2.11		2.0			

RRM STAFFING NEEDS SUMMARY

Last Update: 11/24/04

Program: MESCALERO HOSPITAL(2015MP)

Today's Date: 9/16/05 7:07 PM

RRM Category	Staffing Category	FTEs	Staff Rounded by Discipline/Department
CENTRAL SUPPLY			
	Central Supply Staff	2.01	
	Medical Technician	0.00	
	SUBTOTAL:	2.01	2.0
INTERPRETERS			
	Interpreter	0.00	0.0
DRIVERS			
	Driver	1.38	1.0
RRM DEVIATIONS - ADMINISTRATION			
	ADM_DEV1	0.00	
	ADM_DEV2	0.00	
	ADM_DEV3	0.00	
	ADM_DEV4	0.00	
	SUBTOTAL:	0.00	0.0
Subtotal Administration		**31.12**	**30.0**
FACILITY SUPPORT			
HOUSEKEEPING			
	Janitor/Housekeeper	10.21	10.0
FACILITY MAINTENANCE			
	Maintenance Staff	8.22	8.0
CLINICAL ENGINEERING			
	Clinical Engineering Staff	2.11	2.0
LAUNDRY			
	Laundry staff	1.11	1.0
FOOD SERVICES			
	Food Services Staff	1.00	1.0
MATERIALS MANAGEMENT			
	Warehouseman	2.05	2.0
STAFF HEALTH			
	Registered Nurse	0.51	
	Clerical Support	0.38	
	SUBTOTAL:	0.89	1.0
CLERICAL POOL			
	Facility Support	0.83	1.0
SECURITY			
		1.47	1.0
Subtotal Facility Support		**27.89**	**27.0**
Emergency Medical Services			
EMS			
	EMT-B	**0.00**	
	EMT-I/P	**0.00**	
	Clerks	**0.00**	
	Supervisor	**0.00**	
		0.00	0.0
Subtotal Emergency Medical Services		**0.00**	**0.0**
GRAND TOTAL		**167.78**	**166.0**
		153.68	

Cell F267 is used to calculate staffing that is based on number of staff. This is necessary to prevent loop (error)

Cell I266 is quantity to be used for staffing calculations.

Columns H and I round staff by discipline and department

RRM EMS WORKLOAD

Last Update: 11/24/04

Today's Date: 9/16/05 7:07 PM

RRM STAFFING: 166.00

		MESCALERO HOSPITAL(2015MP)		
	EMS Calcs:	On-Site		
		PCPVs		
1.	**Population:**	**0**		
2.	**% TOTAL RUNS PURCHASED**	**0%**		
3.	**I/T Multiplier**	**0**		
4.	**SQ Kilometers Served**	**0**		
5.	**Annual I/T Runs**	**0**		**Override I/T Runs**
	Raw FTE Projections	**FTE**		
6.	**EMT (Pop.)**	**0.0**		
7.	**EMT (SqK)**	**0.0**		
8.	**EMT (Runs)**	**0.0**		
9.	**SUB_TOTAL**	**0.0**		
10.	**MINIMUM**	**0.0**		
11.	**Staff By Category (Rounded)**			
12.	**EMT-B**	**0.0**		
13.	**EMT-I/P**	**0.0**		
14.	**Clerks**	**0.0**		
15.	**Supervisors**	**0.0**		
16.	**Total FTE**	**0**		

RRM AMBULATORY & COMMUNITY HEALTH WORKLOAD

Last Update: 11/24/04
Today's Date: 9/16/05 7:07 PM

RRM STAFFING: 166.00

		MESCALERO HOSPITAL(2015MP)		
	PRIMARY CARE PROVIDER VISITS	On-Site		
		PCPVs	% Indian	
1.	**Primary Care Provider Visit (PCPVs)**	**27,794**	**100%**	
1a.	**Physical Therapy Visits:**	**1,981**		
1b.	**Total Specialty Visits (TSVs) for Specialty Care:**	**796**		
1c.	**CHP Ambulatory Encounters**			
		Override OPV	**RRM CALC**	
2.	**Outpatient Visits (OPVs)**		**41,719**	
	OUTPATIENT SURGERY	Cases	% Indian	
3.	**Outpatient Surgery**		**100%**	
	EMERGENCY			
4.	**ER PCPVs:**	**2,161**		
	NURSING			
5.	**Emergency Room:**	NO		
6.	**# Patient Escort Hours, if provided:**			
7.	**# of Observation Beds, if provided by the clinic:**			
	PUBLIC HEALTH NURSING			
8.	**Part Time PHN School Services?**	○ Yes		
9.	**Full Time PHN School Service?**	○ Yes		
10.	**No PHN School Service:**	◉ None		
11.	**Discharge Planning by PHN?**	☐ Check if Provided		
12.	**# of Weekly One Hour PHN Managed Clinics:**			
13.	**# of CHRs Supervised**			
14.	**Are Interpreter Services Required?**	NO		
15.	**% of Population Requiring Interpreter Services:**			
	DENTAL			
16.	**Target Minutes Per Dental User:**	**95**		
	CONTRACT HEALTH SERVICES			
17.	**# of CHS PURCHASE ORDERS**	**4,000**		
	OEHE STAFF			
18.	**Number of OEHE Staff**	1		
			RRM STAFFING:	**166.00**

RRM IN-PATIENT WORKLOAD

Last Update: 11/24/04

Today's Date: 9/16/05 7:04 PM

		Program:	MESCALERO HOSPITAL(2015MP)		
	SERVICE CATEGORIES				
	The workload data will be generated from the Health		On-Site Admissions	% Indian	
1.	**ADMISSIONS - OVERRIDE CELL**			STAFFING:	166.00
	ADMISSIONS - CALCULATED CELL		263		
	CASES		On-Site Deliveries/Cases	% Indian	
2.	Projected # of Deliveries			100%	
3.	# Inpatient General Surgical Cases			100%	
4.	# Inpatient Gynecological Surgical Cases			100%	
5.	**Total Number of Beds.**		6		
6.	**Total Number of ICU/CCU Beds**				
7.	**Staffed Observation Beds (Sub-Actue)**				
		DAYS/NURSING STATIONS	On-Site Days	Nurse Stations	
8.	General Medicine		966	1	
9.	Obstetrics/Gynecology				
10.	Surgery				
11.	Pediatrics				
12.	Newborn				
13.	ICU/CCU				
14.	Step-Down Unit				
15.	Operating Room				
16.	Psychiatric				
17.	Ambulatory Care			1	
18.	Birthing Units			0	
19.	Sub Acute			0	
20.	Other :		0	0	RRM Staffing:
		SUBTOTAL:	**966**	**2**	166.00
21.	Nursery: Bassinets:				
22.	Remote Location (Inpatient Special Justification)		NO		
23.	Does Inpatient Nursing Provide Respiratory Services?		YES		
24.	Does Inpatient Nursing Provide EKG Services?		YES		
25.	Yearly Patient Escort Hours (Inter-facility):				

Appendix Q: Program Justification Documents (PJD) MIH

Program Justification Document
Project Name: MESCALERO HOSPITAL(2015) - Community: Mescalero , State: New Mexico
Project Number: AL04ME002H7

Workload Summary...

	Year	Total Workload	Contracted Due To Acuity	Contracted Due To Threshold	Unmet Need	Cross over	HSP Facility Workload	Projected Estimated Facility Workload
Acute Care								
Medical Bed days	***2001***	315	95	221	-1		-1	
	2015	379	114	265				
Pediatric Bed days	***2001***	262	37	225				
	2015	320	45	275				
Surgical Bed days	***2001***	218	78	140				
	2015	267	96	171				
Audiology								
Audiology Visits	***2001***	408			408		408	
	2015	509			509		509	
Clinical Engineering								
Clinical Engineering	***2001***	443			443		443	
	2015	686			686		686	
Dental Care								
Dental Service Minutes	***2001***	400900			400900		400900	
	2015	488965			488965		488965	
Diagnostic Imaging								
CT/MRI Exams	***2001***	35	35					
	2015	64	64					
Fluoroscopy Exams	***2001***	102		102				
	2015	199		199				
General Radiography	***2001***	1479		1479				
	2015	2698			2698		2698	
MAMMOGRAPHY	***2001***	430		430				
	2015	519		519				
Ultrasound Exams	***2001***	204		204				
	2015	398		398				
Education & Group Consultation								
# of staff	***2015***	142			142		142	
Emergency								
Emergency Room Visits	***2001***	1769			1769		1769	
	2015	2161			2161		2161	
Eye Care								
Optometrist Visits	***2001***	1303			1303		1303	
	2015	1589			1589		1589	
Facility Management								
Service index	***2001***	20			20		20	
	2015	31			31		31	
Housekeeping & Linen								

Program Justification Document
Project Name: MESCALERO HOSPITAL(2015) - Community: Mescalero , State: New Mexico
Project Number: AL04ME002H7

Workload Summary...

	Year	Total Workload	Contracted Due To Acuity	Threshold	Unmet Need	Cross over	HSP Facility Workload	Projected Estimated Facility Workload
Lbs of Linen	**2001**	7396			7396		7396	
	2015	10593			10593		10593	
Intensive Care								
Intensive Care bed days	**2001**	51	23	28				
	2015	64	29	35				
Laboratory								
Chem/Hema/Immun/Urin	**2001**	12702	762		11940		11940	
	2015	24362	1462		22900		22900	
Histo/Cytology billable	**2001**	81	81					
	2015	120	120					
Microbiology billable tests	**2001**	3017	1207		1810		1810	
	2015	5488	2195		3293		3293	
Transfusion/BB billable	**2001**	244	5		239		239	
	2015	468	9		459		459	
Mental Health								
Mental Health Visits	**2001**	732			732		732	
	2015	891			891		891	
Pharmacy								
Inpatient Pharmacy	**2001**	-5			-5		-5	
	2015							
Outpatient Pharmacy	**2001**	195975			195975		195975	
	2015	365590			365590		365590	
Physical Therapy								
Inpatient Physical Therapy	**2001**							
	2015							
OUTPATIENT PHYSICAL	**2001**	1626			1626		1626	
	2015	1981			1981		1981	
Primary Care								
Primary Care Provider	**2001**	14071			14071		14071	
	2015	17155			17155		17155	**27794**
Property & Supply								
Storage Index	**2001**	3588			3588		3588	
	2015	7087			7087		7087	
Psychiatric Nursing								
Psych Bed days	**2001**	55	12	43				
	2015	72	16	56				
Public Health Nursing								
Public Health Nursing	**2001**	1149			1149		1149	
	2015	1394			1394		1394	

Program Justification Document
Project Name: MESCALERO HOSPITAL(2015) - Community: Mescalero , State: New Mexico
Project Number: AL04ME002H7

Workload Summary...

	Year	Total Workload	Contracted Due To Acuity	Threshold	Unmet Need	Cross over	HSP Facility Workload	Projected Estimated Facility Workload
Respiratory Therapy								
Respiratory Therapy work	***2001***	16757		16757				
	2015	27985		27985				
Specialty Care								
Specialist Visits	***2001***	651		651				
	2015	796		796				
Sub-Acute								
SubAcute Bed days	***2001***	332		332				
	2015	408		408				
Surgery								
Inpatient Episodes	***2001***	112	31	81				
	2015	129	36	93				
Outpatient Episodes	***2001***	125	35	90				
	2015	154	43	111				

Program Justification Document
Project Name: MESCALERO HOSPITAL(2015) - Community: Mescalero , State: New Mexico
Project Number: AL04ME002H7

Current / Projected User Population... *inpatient - (AC)*

(Acute Care, Audiology, Dental Care, Diagnostic Imaging, Emergency, Eye Care, Intensive Care, Labor & Delivery/Nursery, Mental Health, Physical Therapy, Primary Care, Psychiatric Nursing, Public Health Nursing, Specialty Care, Sub-Acute, Surgery)

MESCALERO - LINCOLN CO O (LINCOLN) M/S: cur) 100.0% prj) 100.0%

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur) 2001		4	4	4	3	1		1	1			18
prj) 2015		6	6	6	4	1		1	1			25
Female												
cur) 2001		1	3	3	2	7	8	6	2		1	33
prj) 2015		1	4	4	3	10	11	8	3		1	45

MESCALERO - MESCALERO OS (OTERO) M/S: cur) 100.0% prj) 100.0%

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur) 2001	1	8	7	4	10	10	12	11	5	2	1	71
prj) 2015	1	10	9	5	12	12	15	13	6	2	1	86
Female												
cur) 2001	1	9	8	4	11	5	9	15	10	1	3	76
prj) 2015	1	11	10	5	13	6	11	18	12	1	4	92

MESCALERO - MESCALRO RES (OTERO) M/S: cur) 100.0% prj) 100.0%

Male	<1	1 4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur) 2001	37	153	171	186	182	140	250	205	139	58	40	1561
prj) 2015	45	187	209	227	222	171	305	250	170	71	49	1906
Female												
cur) 2001	29	139	165	183	197	156	241	246	150	81	66	1653
prj) 2015	35	170	202	224	241	191	294	300	183	99	81	2020

MESCALERO - N TULAROSA C (OTERO) M/S: cur) 100.0% prj) 100.0%

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur) 2001									2			2
prj) 2015									2			2
Female												
cur) 2001												
prj) 2015												

MESCALERO - NOGAL (OTERO) M/S: cur) 100.0% prj) 100.0%

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur) 2001												
prj) 2015												
Female												
cur) 2001		1										1
prj) 2015		1										1

Totals...

Male	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	Total
cur) 2001	47	197	240	246	226	187	326	257	176	74	47	**2023**
prj) 2015	56	241	295	301	276	228	396	313	214	89	56	**2465**
Female												
cur) 2001	32	189	214	258	252	210	317	331	208	101	85	**2197**
prj) 2015	38	230	263	315	308	257	387	404	254	123	103	**2682**
Combined												
cur) 2001	**79**	**386**	**454**	**504**	**478**	**397**	**643**	**588**	**384**	**175**	**132**	**4220**
prj) 2015	**94**	**471**	**558**	**616**	**584**	**485**	**783**	**717**	**468**	**212**	**159**	**5147**

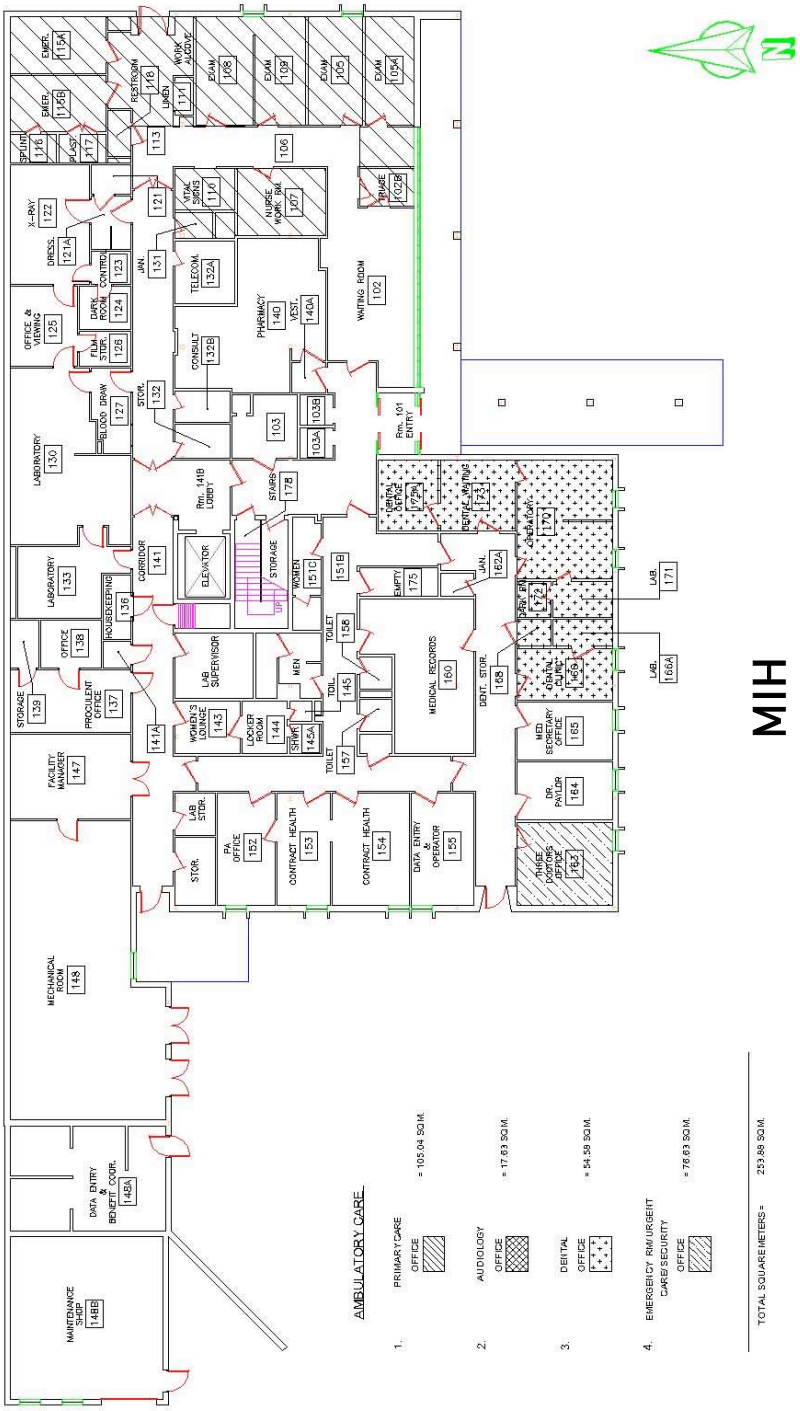
Average Age for the Service Unit: **25.8**

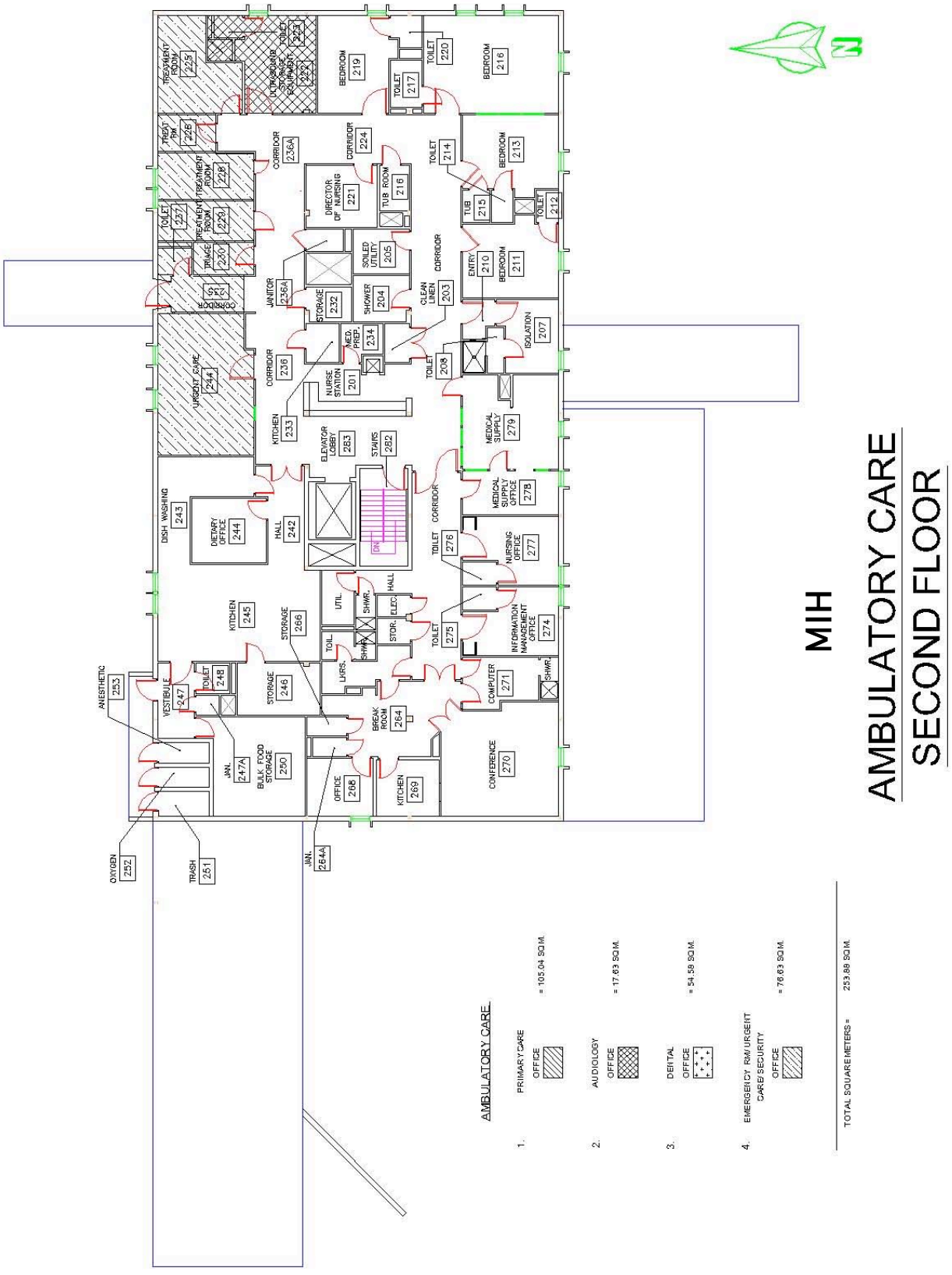
Appendix R: Facility Space Utilization Comparisons: 2005 to Projected Need 2015

Draft SPACE SUMMARY PLAN (Mescalero Hospital Year 2015)

Existing net and gross areas for the proposed facility are summarized below, without inpatient care

MESCALERO IH	Net Square Meters	Conversion Factor	Gross Sq Meters CURRENT	Gross Sq Meters 2015
ADDITIONAL SERVICES				
X01			1.35	8.1
X02			1.35	27
X03			1.35	493.29
ADMINISTRATION				
Administration	213.85	1.4	299.39	270.2
Business Office	97.13	1.4	135.98	155.4
Health Info Manage				241.25
Information Manage	76.25	1.2	91.5	75.6
AMBULATORY				
Dental	54.58	N/A	54.58	653
Emerg/Urgent/Security	76.63	N/A	76.63	82
Eye Care				163
Primary Care	105.04	N/A	105.04	487
Primary Care				487
ANCILLARY				
Diagnostic Imaging	40.65	N/A	40.65	126
Laboratory	55.73	N/A	55.73	157
Pharmacy	33.94	N/A	33.94	252
Physical Therapy				149
BEHAVIORAL				
Mental Health/Social Work				165.2
Social Work				
FACILITY SUPPORT				
Facility Management	126.86	N/A	126.86	100
PREVENTIVE				
Environmental Health				36.4
Health Education				22.4
Public Health Nursing				151.2
Public Health Nutrition				28
NUTRITION SUPPORT SERVICES				
Education & (egc1)				74
Group Consultation				
Education & (EGC)				19.8
Group Consultation				
Employee Facilities				186.48
Housekeeping & Linen (hl2)				56
Housekeeping & Linen (HL)	4.98	1.1	5.47	17.6
Property & Supply				323
Public Facilities				75.6
TOTALS		**Department Gross Square Meters**		**5082.52**
		Building Circulation & Envelope (.20)		**1016.5**
		Floor Gross Square Meters		**6099.02**
		Major Mechanical SPACE (.12)		**731.88**


MIH
AMBULATORY CARE
FIRST FLOOR
N
AMBULATORY CARE
1. PRIMARY CARE
OFFICE = 105.04 SQ.M.
2. AUDIOLOGY
OFFICE = 17.63 SQ.M.
3. DENTAL
OFFICE = 54.59 SQ.M.
4. EMERGENCY RM/URGENT CARE/SECURITY
OFFICE = 76.63 SQ.M.
TOTAL SQUARE METERS = 253.88 SQ.M.


N
MIH
AMBULATORY CARE
SECOND FLOOR
AMBULATORY CARE
1. PRIMARY CARE
OFFICE = 105.04 SQ.M.
2. AUDIOLOGY
OFFICE = 17.83 SQ.M.
3. DENTAL
OFFICE = 54.58 SQ.M.
4. EMERGENCY RM/ URGENT CARE/ SECURITY
OFFICE = 76.63 SQ.M.
TOTAL SQUARE METERS = 253.88 SQ.M.